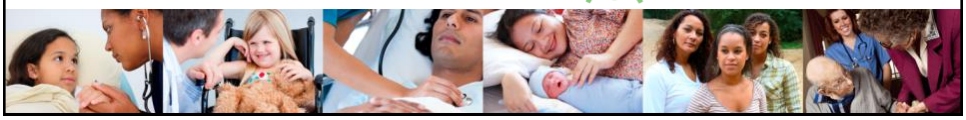
Guest
Password: **cloakroom**

Health Care Begins With Home:
Understanding How Medicaid and Housing Work Together

Jennifer McGuigan Babcock, VP, Medicaid Policy
Association for Community Affiliated Plans

September 13, 2018

ACAP
Association for Community Affiliated Plans



1

Health Care Begins With Home:
Understanding How Medicaid and Housing Work Together

- ✓ **Welcome & Introductions**
  - **Jenny Babcock,** VP of Medicaid Policy, ACAP
- **The Big Picture**
  - **Enrique Martinez-Vidal**, VP of Quality & Operations, ACAP
- **Insight from Medicaid Managed Care Plans**
  - **Amy Riegel**, Director of Housing, CareSource
  - **Alison Klurfeld**, Director of Safety Net Programs, L.A. Care
  - **John Lovelace**, President, UPMC *for You*
- **Questions & Answers**

ACAP

2

About ACAP

Mission:
To strengthen not-for-profit Safety Net Health Plans in their work to improve the health of lower-income and vulnerable populations.

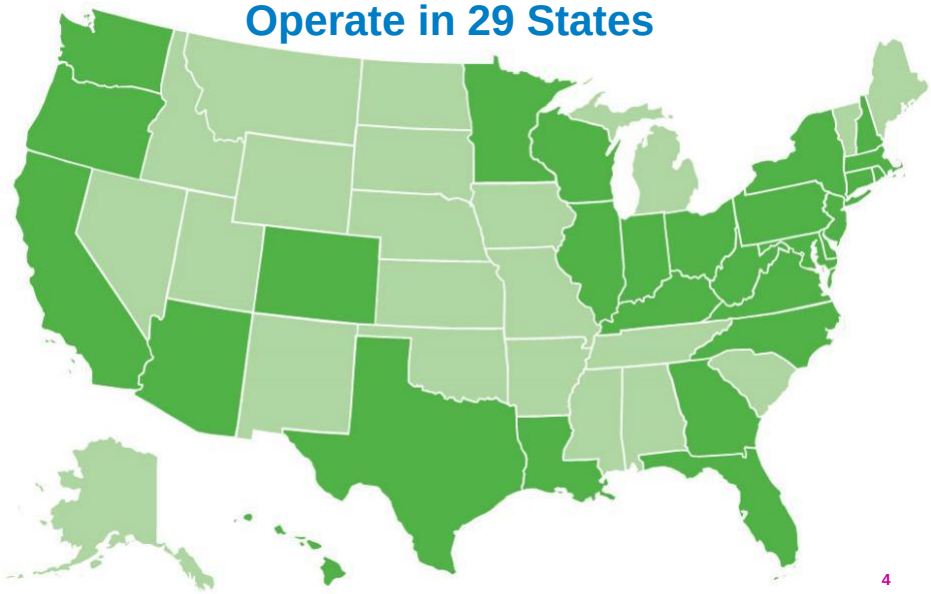
Vision:
To improve the health and well-being of lower-income and vulnerable populations and the communities in which they live.

ACAP

3

3

ACAP's 62 Member Safety Net Health Plans Operate in 29 States



4

4

Health is Determined by More Than Health Care

Social Determinants:
- **Housing**
- **Nutrition**
- **Education**
- **Employment**
- **Social Supports**
- **Transportation**
- **Public safety**

Critical Environments:
- **Homes**
- **Schools**
- **Workplaces**
- **Neighborhoods**
- **Communities**

ACAP

5

Medicaid Health Plans Are Supporting Housing Efforts

- Bridging the Health and Housing Gap (2017)
  - Describes the looming demographic shift to a greater proportion of people who are elderly and disabled
  - Provides an overview of federal housing and Medicaid policies related to long-term services and supports, including housing supports
  - Highlights Medicaid health plan efforts on transitional housing
- Breaking the Health and Housing Silos to Address Chronic Homelessness (2018)
  - Summarizes federal Medicaid and housing policy that impact homeless Medicaid enrollees
  - Outlines a variety of solutions Medicaid health plans have implemented, along with ongoing challenges

ACAP

6

More than 500,00 People in the U.S. are Homeless on a Given Night

- **About 1 in 6 are considered to be "Chronically Homeless"**
- **~5 in 6: Transitional Homeless**

Transitional Homelessness for Clinical Reasons:

Individuals who end up in a hospital, skilled nursing facility or long-term care and subsequently lose their home and therefore **cannot be discharged**

ACAP

7

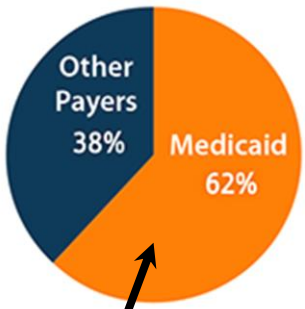
In Addition, An Aging Population Will Experience Growing Long Term Care Needs

1 in **3** people turning 65 will require nursing home care at some point during his or her life

$82,000

Typical annual cost of nursing home care in 2016, which is nearly 3x the annual income of most seniors

Medicaid covers **6** in **10** nursing home residents.



$55 billion in **2015**
~10% of total Medicaid spend

ACAP

8

Federal Policy Currently Allows Medicaid to Pay for Some Housing

- Roughly 50 percent of patients at community health centers with a focus serving people who are homeless are on Medicaid
- State Medicaid options for funding social interventions*
  - Classify social services as covered benefits under state plan.
  - Use Section 1115 demonstrations (must be budget neutral); states may also use Section 1915 waivers for housing efforts.
  - Use payment innovations, such as value-based payments, incentives, withholds, and enhanced rates, to support plans.
  - Integrate social interventions into quality activities.
  - Provide higher rates to plans that invest in housing efforts.
  - Other Medicaid funding options
    - Permanent Supportive Housing
    - Balancing Incentive Payments
    - Money Follows the Person
    - *Affordable Care Act* Health Homes

ACAP

* Bachrach, D. and Guyer, J. Practical Strategies for Integrating the Cost of Social Interventions into Medicaid Managed Care Rates. Health Affairs, March 7, 2018.

9

Federal Housing Policies Support Affordable Housing for Individuals Who Are Homeless

- Housing Choice Voucher Program (Section 8)
  - Caveat: eligibility does not align with Medicaid eligibility
- Section 202 Supportive Housing for the Elderly
- Section 811 Housing for Persons with Disabilities
  - *Frank Melville Supportive Housing Investment Act of 2010*
- LIHTC provides tax incentives to developers to create affordable housing units.
- HOME provides block grants to states and localities
  - Helps fund the payment for building/rehabilitating affordable low-income housing units
  - Largest Federal block grant designed for this purpose.

ACAP

10

Thank you.

ACAP

11

ACAP
Association for Community Affiliated Plans

Health Care Begins with Home: Understanding How Medicaid and Housing Work Together

The Big Picture: Social Determinants of Health Today

Enrique Martinez-Vidal, VP, Quality and Operations

Association for Community Affiliated Plans

September 13, 2018

12

Role of Health Care Funding in Addressing SDH Services

Alternative Payment Models

- Community Benefits
- Operations (e.g., Employment, Procurement and Investment)
- Performance Indicators (1)
- Shared Savings (2)
- Shared Risk (3)
- Bundled Payment (4)
- Comprehensive Population-Based Payment (5)

Engagement Vehicles

- Direct Payment
- Partnering w/Fin Institutions (CDCs, CFDIs)
- Direct Workforce (i.e. Social Workers, CHWs)
- Community Benefit Investments
- Contracting with CBOs
- Contracting with Non-Health Care Government Agencies
- Collaborations

Engagement Enablers – *Conceptual*

- Leadership
- Cross-Sector Consensus Building and Strategic Alignment
- Transparency

Engagement Enablers – *Operational*

- Data Collection (Environmental Scan)
- Data Analysis/Measurement (Evidence Generation and ROI)
- Data Infrastructure
- Collaborations
- Convenings
- Communication
- Practice Transformation
- Trusted Convener

Social Determinants of Health (Community Resources) (6)

- Housing
- Food Security
- Education
- Employment
- Transportation
- Healthy Behaviors
- Neighborhood and Built Environment

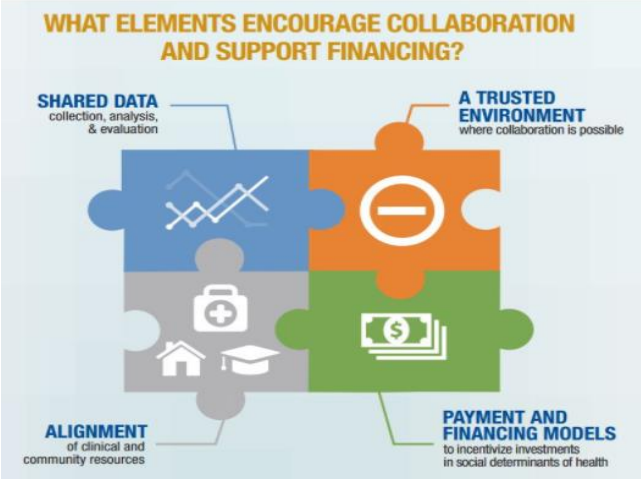
1. Financial Bonus for meeting quality / cost targets
2. Upside risk only
3. Upside and downside risk
4. Episodic or condition-specific billing
5. Capitation / Global Budgets
6. Components from Healthy People 2020

Source: AcademyHealth Blog. *Why Doesn't Payment Reform Support Population Health? A Look at the Barriers,* December 2016. http://www.academyhealth.org/blog/2016-12/why-doesnt-payment-reform-support-population-health-look-barriers

ACAP

13

13



Source: AcademyHealth. Payment Reform for Population Health http://www.academyhealth.org/about/programs/payment-reform-population-health

ACAP

14

14

Social Determinants of Health and Medicaid

- SDH play a key role in health outcomes
  - 95% of health spending is devoted to direct medical services, but nearly half of all deaths are attributable to non-medical indicators
- Evidence that addressing SDH can improve health outcomes and reduce health care spending
  - Medicaid beneficiaries with stable housing found to spend significantly less on health care
- Medicaid exploring programmatic and policy changes to address SDH
  - It operates in all 50 states
  - As a federal-state partnership it can be tailored to needs of each state
  - It already has experience serving diverse populations
  - SDH disproportionately have an impact on the health of low-income individuals

Source: Center for Health Care Strategies. Webinar: *State Approaches to Providing Health-Related Supportive Services through Medicaid*, June 2, 2016. https://www.chcs.org/media/Supportive-Services-through-Medicaid-Webinar-060216.pdf

ACAP

15

Payment Can Drive System Transformation

Status Quo (Volume-Based) System	Transformed (Value-Based) System
Fragmented clinical and financial approaches to care delivery	Integrated systems that pay for and deliver whole person care
Uncoordinated care and transitions	Coordinated care and transitions
Unengaged members left out of their own health care decisions	Engaged and activated members who are connected to the care they need and empowered to take a greater role in their health
Variation in delivery system performance (cost and quality) with no ties to clinical or financial accountability and transparency	Standardized performance measurement with clinical and financial accountability and transparency for improved health outcomes

Source: Washington Health Care Authority, *Healthier Washington & Paying for Value: Transforming Health in Washington State.* AcademyHealth and Nemours Children's Health System Payment Reform for Population Health Workshop, July 2017.

ACAP

16

State Medicaid Reimbursement Strategies

Program	Payment Model	Examples of Services Offered
Massachusetts *Children's High-Risk Asthma Bundled Payment*	• Bundled Payment	• Home visits from community health workers • Environmental mitigation supplies
New York *Supportive Housing Services*	• State-only Medicaid funds	• Rental subsidy assistance • Job training • Tenancy support/meditation
Oregon *Coordinated Care Organizations*	• Global budget	• Education/training • Self-help/support group • Home remediation
Utah *Accountable Care Organizations (ACOs)*	• Risk-adjusted, capitated model with annual increase of no more than 2%	• Home remediation • Housing Assistance
Vermont *Blueprint for Health/Support and Services at Home (SASH)*	• Per beneficiary, per month payment • Capacity payment to Community Health Teams	• Nutritional education • Self-help/support group

Source: Center for Health Care Strategies. *Using Medicaid Resources to Pay for Health-Related Supportive Services: Early Lessons*, December 2015. http://www.chcs.org/media/Supportive-Services-Brief-Final-120315.pdf

ACAP

17

Medicaid's Role in Social Support Services: Comprehensive Efforts

***Oregon:* Coordinated Care Organizations (CCOs)**

- Created incentives for CCOs to address SDHs
- Models of care that connect the clinical experience to community social services that fully address the needs of families
- Alternative payment models that focus on value rather than volume
- Oregon's waiver gave CCOs flexibility to provide non-medical services that result in better health/lower costs – examples:
  - Housing supports & services; Wellness (e.g., exercise shoes and classes); Mental health & counseling (e.g., mental health professionals embedded in school systems; employment counseling to support job searches)

***Washington:* Healthier Washington**

- Changing the way they pay for care: value-based health options and innovative programs
- Changing the way they work together to improve the health of populations (i.e., Accountable Communities of Health; leveraging incentives to encourage clinical-community linkages
- Leveraging data and evidence-based recommendations
- Educating and engaging people and their families

Source: Oregon Health Authority, *Medicaid and Upstream Prevention: Oregon's Approach* and Washington Health Care Authority, *Healthier Washington & Paying for Value: Transforming Health in Washington State.* AcademyHealth and Nemours Children's Health System Payment Reform for Population Health Workshop, July 2017.

ACAP

18

Medicaid's Role in Social Support Services: Comprehensive Efforts

***Massachusetts:* Medicaid Accountable Care Organizations (ACOs)**

- ACOs: groups of doctors, hospitals and other health care providers working together to provide effective, efficient, coordinated care for members
- Payment: Value (positive outcomes and treatments based on evidence of effectiveness) rather than volume (e.g., capitation; shared savings—while meeting quality metrics)
- Enhanced care delivery models:
  - Care Needs Screenings and Comprehensive Assessment
  - Care Management and Care Coordination
  - Community Partners: behavioral health or LTSS care management expertise
  - Flexible Services: non-medical social influences on health

Source: Massachusetts Medicaid Policy Institute, *What to Know about ACOs: An Introduction to MassHealth Accountable Care Organizations*, July 2018. https://bluecrossmafoundation.org/publication/what-know-about-acos-introduction-masshealth-accountable-care-organizations

ACAP

19

More State Examples: Medicaid's Role in Social Support Services

Linkages to Noncovered Social Services:

- *Colorado*: Per-member-per-month (PMPM) payment for care coordination including social service referrals
- *Michigan*: Community Health Workers/Peer Specialists to help arrange for social services
- *Maine*: Health Home that may include Community Care Teams for high-needs patients

Housing Services:

- *Louisiana*: Supportive housing for certain special-needs populations
- *Texas*: Managed care organizations must participate in program to pay for minor home modifications to ensure safety, security and accessibility of the home

Employment Services:

- *Maryland*: Habilitation services (through Home and Community Based Services [HCBS] waiver) for children and adults with developmental disabilities

Peer Support Services:

- *Georgia*: For enrollees with serious mental illness (SMI) under rehabilitative services option
- *Kansas*: Health Homes with peer support specialists as required members of provider teams for beneficiaries with SMI

Source: Manatt Health, *Medicaid Coverage of Social Interventions: A Road Map for States*, Millbank Memorial Fund Issue Brief, July 2016.

ACAP

20

Medicaid Challenges to Investing in SDHs

- Making the business case to payers/MCOs for investing in upstream prevention.
- Understanding what Medicaid can and cannot pay for.
- States, health plans, and providers often feel like they are always breaking new ground when determining which upstream interventions to deploy.
- Medicaid cannot adequately address and invest in SDH on its own—it must partner with other agencies and community-based organizations

Source: AcademyHealth and Nemours Children's Health System, *Innovative Medicaid Strategies for Upstream Prevention and Population Health*, February 2018. http://www.academyhealth.org/page/medicaid-payment-strategies-financing-upstream-prevention

ACAP

21

Medicaid Opportunities for Investing in SDHs

- Have the right people at the table.
- Allow flexibility on how to accomplish goals.
- Identify and build on proven approaches to upstream prevention investments.
- Look for ripe opportunities for cross-sector alignment among specific populations, such as children.
- Employ strategies that link traditional clinical care with community-based prevention initiatives as a portfolio of investments.
- Focus interventions on the family as the unit of partnership.
- Engage CMS as a partner, rather than viewing them as only a payer.
- Think broadly about ways to use payment reform, rather than addressing a specific issue.
- Harness the flexibility under current federal Medicaid regulations.

Source: AcademyHealth and Nemours Children's Health System, *Innovative Medicaid Strategies for Upstream Prevention and Population Health*, February 2018. http://www.academyhealth.org/page/medicaid-payment-strategies-financing-upstream-prevention

ACAP

22

For further information:

- Visit ACAP's website
  www.communityplans.net
- Contact ACAP
  emartinez-vidal@communityplans.net

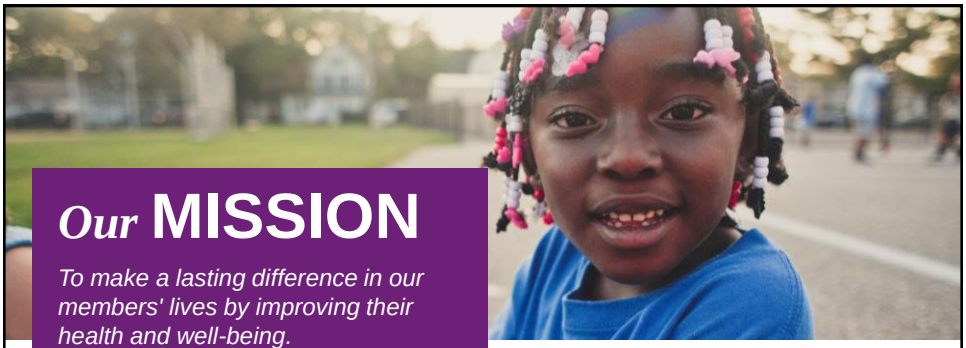
ACAP

23

Housing *Interventions*

CareSource
LIFE SERVICES

24

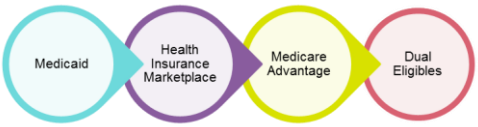


Our MISSION

To make a lasting difference in our members' lives by improving their health and well-being.

CARESOURCE

- A nonprofit health plan and national leader in Managed Care
- Nearly 30 year history of serving low-income populations across multiple states and insurance products
- Currently serving members in Georgia, Indiana, Kentucky, Ohio and West Virginia
- 4,000 employees located across 21 states



2M members

Confidential & Proprietary

CareSource

25

Why housing?

Low-income adults receiving housing assistance are more likely to report **better health outcomes** and psychological well-being than those on waitlists.

People who are stably housed are **less likely than people who are homeless to visit the emergency room**. If they're admitted into the hospital, they typically have a shorter stay and are less likely to be readmitted within 30 days.

Adults who worry about paying rent are more likely to report **smoking**, being in fair or **poor health**, having **depression**, **delaying doctor visits**, and **lacking enough sleep** than those who never or rarely worry about affording housing expenses.

Among food-insecure families eligible for rental assistance, **infants** whose families received rental assistance during the prenatal period were **less likely to be hospitalized**.

Source: Shelterforce, The Answer, bit.ly/SF189TheAnswer

CareSource

HOUSING & NEIGHBORHOODS

- ACCESS TO HEALTHY FOODS
- INCREASED QUALITY OF SAFE & AFFORDABLE HOUSING
- IMPROVED ENVIRONMENTAL CONDITIONS

26

CareSource *Housing Strategy*

Develop formal partnership to address **housing stability** including foreclosure and eviction prevention programs

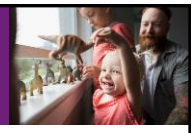
Develop partnership with national housing groups or developers to assist members seeking housing or moving between housing options

Seek financial or investment tools to support the **development of affordable housing**

Advocacy effort to expand voucher program or **create a new housing program** for those who are not eligible for traditional subsidized housing

Confidential & Proprietary

What we are *doing?*



HEALTHY BEGINNINGS AT HOME

Pilot program with CelebrateOne, the Ohio Finance Agency and Columbus Metropolitan Housing Authority

Targeting homeless or near homeless pregnant women

Providing rental subsidies, housing stabilization services and community based services

GOAL: Evaluate whether having stable housing improves birth outcomes, reduces infant mortality and improves moms health outcomes

SENIOR LIVING

Developing a permanent supportive housing model for frail, older adults residing in nursing homes or long-term care rehabilitation centers who could be living in lower-level care settings, as well as individuals living in substandard housing who are isolated from social services

Working with an Ohio real estate developer that owns a senior living complex to incorporate telehealth and other services into the housing units

INMATE TRANSITIONAL ASSISTANCE

Providing transitional assistance to prison inmates who have been receiving behavioral health services and who will become Medicaid-eligible upon release

Offering employment support and at least 90 days of housing for individuals

Focusing on what's possible.

Confidential & Proprietary

CareSource

CareSource®
© 2018 CareSource. All Rights Reserved
June 2018
Confidential & Proprietary

29

L.A. Care
HEALTH PLAN
For All of L.A.
Health Plan Collaboration
to Advance Supportive Housing
Alison Klurfeld, Director of Safety Net Programs & Partnerships
ACAP Social Determinants of Health Briefing
September 13, 2018
ELEVATING HEALTHCARE
IN LOS ANGELES COUNTY
SINCE 1997

30

About L.A. Care Health Plan

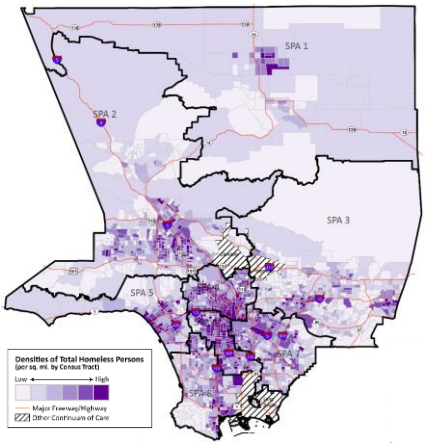
www.lacare.org

L.A. Care Health Plan is a public entity and community-accountable health plan serving residents of Los Angeles County through a variety of health coverage programs including Medi-Cal (California's Medicaid Program), L.A. Care Covered™, L.A. Care Cal MediConnect Plan, and PASC-SEIU Homecare Workers Health Care Plan.

L.A. Care is a leader in developing new programs through innovative partnerships designed to provide health coverage to vulnerable populations and to support the safety net. With more than 2 million members, L.A. Care is the nation's largest publicly operated health plan.

L.A. County Context

- Challenges
  - Large unsheltered homeless population
  - High health burden
  - Affordable housing shortage
- Opportunities
  - Local commitment to end homelessness
  - Local investment via Public / Private Partnership
  - Health & homeless services partnerships to build on

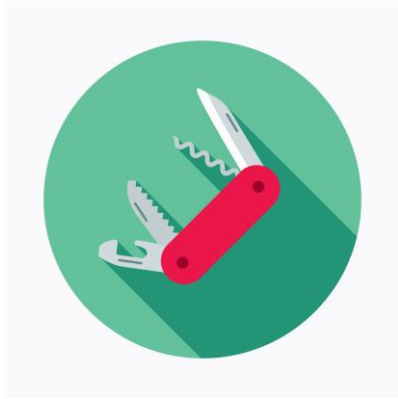


2018 LAHSA Homeless Count:
https://www.lahsa.org/homeless-count/reports

Medicaid and Housing are interdependent

Supportive housing is a tool for:

Ending homelessness

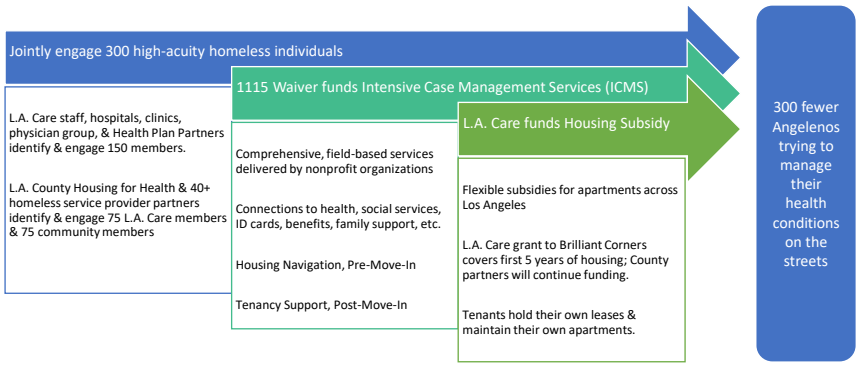


Addressing health needs

33

Housing for Health & Brilliant Corners Grant & Referral Partnership

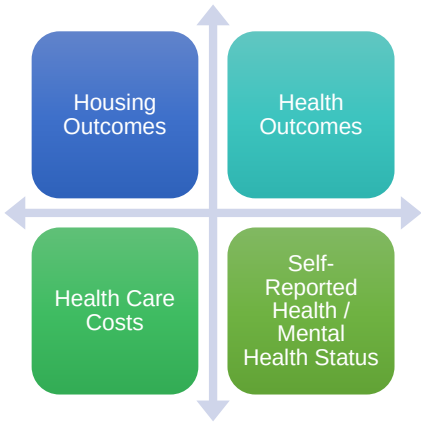
L.A. Care has made a $20 million, five year commitment to L.A. County Housing for Health via fiscal intermediary Brilliant Corners.*



*Contingent upon grantee performance, availability of funds, & board approval.

34

Developing evidence for supportive housing value proposition



Sources:
- Hunter, Sarah B., Melody Harvey, Brian Briscombe, and Matthew Cefalu, *Evaluation of Housing for Health Permanent Supportive Housing Program*, Santa Monica, Calif.: RAND Corporation, RR-1694-BRC, 2017. (https://www.rand.org/pubs/research_reports/RR1694.html)
- National Academy of Science, *Permanent Supportive Housing Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness*, July 2018. (http://nationalacademies.org/hmd/Reports/2018/permanent-supportive-housing.aspx)
- Ly A, Latimer E. Housing First Impact on Costs and Associated Cost Offsets: A Review of the Literature. *Canadian Journal of Psychiatry Revue Canadienne de Psychiatrie*. 2015;60(11):475-487.
- Supportive Housing Network of New York, Cost Savings Research (https://shnny.org/research-reports/research/cost-savings/)

35

36

Thank you!

Alison Klurfeld, MPP/MPH
Director of Safety Net Programs & Partnerships
L.A. Care Health Plan
(213) 694-1250, x5745
aklurfeld@lacare.org

37

UPMC LIFE CHANGING MEDICINE

Housing is Health

John Lovelace
President, UPMC for You, Inc.
President, Government Programs & Individual Advantage
UPMC Health Plan

38

UPMC: Global Academic Integrated Delivery and Finance System

UPMC LIFE CHANGING MEDICINE

85,000 employees & $17 B Revenue

Insurance Services

- **3.4 M Members**
- **Top ranked Quality**
- **4.5 Star Medicare**
- **Service Excellence: Stevie Award Winner**

Health Services Division

- 30+ hospitals
- 500 outpatient locations
- 310,000 IP admissions
- 4.2 outpatients visits
- 3,800 employed physicians
- 5,700 total physicians

UPMC Enterprises

evolent HEALTH
omnyx
Prodigo SOLUTIONS
Health Fidelity

UPMC International Services

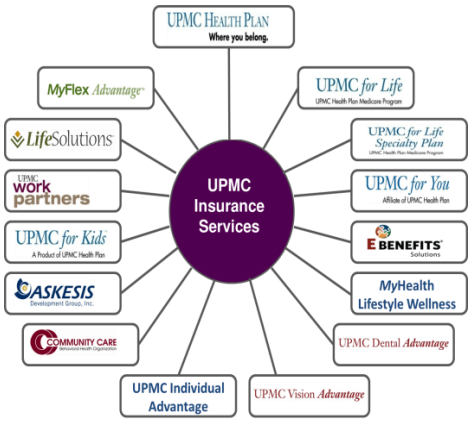
- 20+ countries
- Hospitals: Italy
- Established partnerships in: Italy, Ireland, China, Columbia, and Kazakhstan

39

UPMC LIFE CHANGING MEDICINE

39

UPMC Insurance Services: A Diverse Product Portfolio



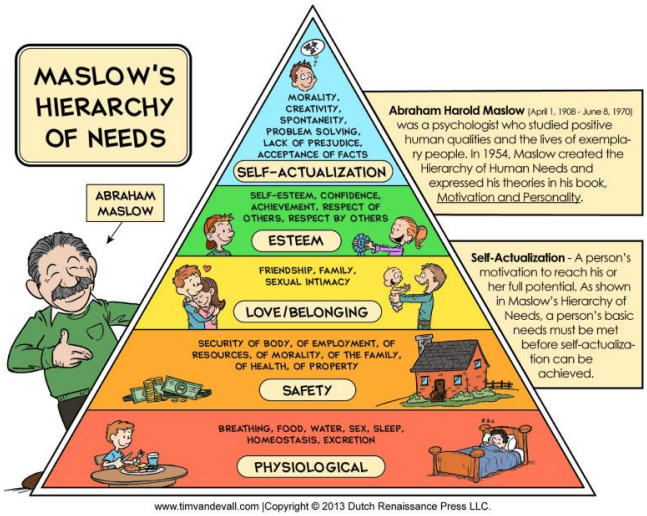
- **2nd Largest in Nation Provider Led**
- **3rd Largest Insurer Operating in PA**
- **Over 3.4 M Members**
- **Annual revenues $7 B (run rate)**
- **10,000+ Employer groups**
- **Fastest growing Medicaid and CHIP Plan**
- **Top tier Medicaid plan in PA**
- **4 Star Medicare Dual Special Needs Plan**
- **10th Largest SNP Nationally**
- **Top 10 Nationally in Medicaid Quality**
- **Highest Ranked Provider Satisfaction (PA)**
- **J.D. Power Certified Call Center**
- **National Business Group on Health Platinum Winner**
- **2012 Global Call Center of the Year Awardee (ICMI)**

40

UPMC LIFE CHANGING MEDICINE

40

Maslow's Hierarchy of Needs: *Take 1*



UPMC LIFE CHANGING MEDICINE

41

Maslow's Hierarchy of Needs: *Take 2*

UPMC LIFE CHANGING MEDICINE

42

Housing is Health: Two Pillars

Member-Specific Programming

- Cultivating Health for Success
- Forthcoming Expansion of CHFS

Member Agnostic Investments:

- Community-level tax credits and other investments
- Macro-level: Aligning for Health

UPMC LIFE CHANGING MEDICINE

43

Cultivating Health for Success: The Concept

Criteria:

- Must be HUD homeless (not Chronically Homeless)
- Have UPMC For You Medicaid or Special Needs Plan
- Have at least 1 year of high health care expenditures
- Willing to work with care managers to develop a health plan
- Able to live independently

Current Dynamics:

- 25 members (fluctuates) currently housed and connected with UPMC Health Plan Community Team (Clinical Care Manager and Community Health Worker)
- Participants are in scattered-site permanent housing
- CoC PSH Grant from HUD for $361,781 for rental assistance and administration costs
- UPMC for You provides ~$150k/yr including contract for ~$95k to CHS for supportive services (Personnel, administration, client assistance, insurance, staff travel, communications and equipment) – *to offset our costs, 24 members must be successfully housed*

UPMC LIFE CHANGING MEDICINE

44

The Approach

A Truly **INTEGRATED** Approach

Community Human Services – HUD Staff	UPMC – Mobile Clinical Care Manager (Nurse)	UPMC – Community Health Worker
Housing Search and Move-In Assistance	Care Management	Connection to appointments
Ongoing Rental Support	Medication Management	Linkages to community resources
Landlord Mediation	Referral to specialty care	
Housing Supports	Some testing	

- ✓ CHS and UPMC frontline staff meet bi-weekly for case coordination and daily huddle calls
- ✓ CHS and UPMC frontline and Administrative staff meet monthly for deep case conferencing
- ✓ CHS gets alerted if member goes to into ER or gets admitted

UPMC LIFE CHANGING MEDICINE

45

The Results

Outcomes from 5-year Longitudinal Study:

- **85% of eligible members were successfully housed (some found other means for housing)**
- **Unplanned medical cost decreased after housing was established. There was an observable decrease in facility days after housing.**
- **Enrollment in the program was associated with an increase in PCP and specialist visits. Planned office visits doubled after housed.**
- **Additional increase in visits was observed once participant was stably housed**
- **Medical cost decreased after housing. Pharmacy cost continued to increase (due to planned medication management)**

Basically….

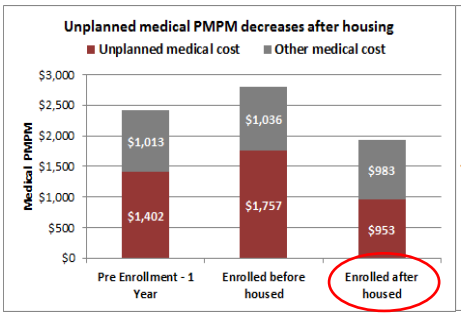
- ✓ **Unplanned Care Costs Decreased**
- ✓ **Rates of Primary/Specialty Visits Doubled**
- ✓ **Pharmacy Costs Increased**
- ✓ **It worked!**

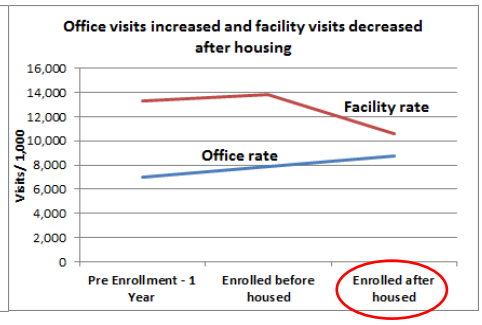
** Source: UPMC Health Plan. Department of Health Economics HUD Initiative Analysis. August 2016. Longitudinal 5-year Year Impact Analysis.*

UPMC LIFE CHANGING MEDICINE

46

More Results





*Source: UPMC Health Plan. Department of Health Economics HUD Initiative Analysis. May 2017. Results based on 32 housed members within 2-year membership over CY 2015 and CY2016 vs. a comparison group of homeless members

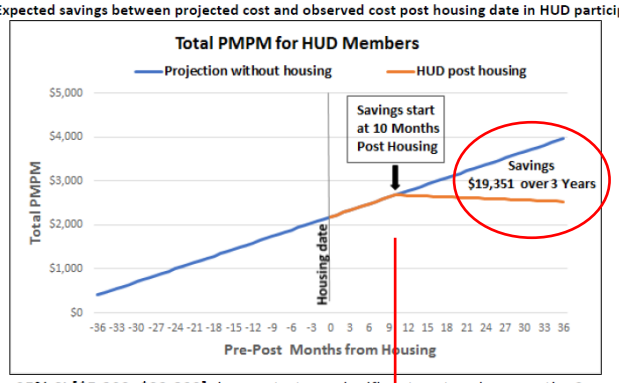
UPMC LIFE CHANGING MEDICINE

47

47

Better Care + Housing = Bending the Cost Curve

Figure 1: Expected savings between projected cost and observed cost post housing date in HUD participants.



Note: The **95% CI [$5,809, $32,892]** demonstrates a significant cost saving over the 3 years.

✓ **Maintaining housing = significant savings!**

UPMC LIFE CHANGING MEDICINE

48

48

Expansion of Cultivating Health for Success

- Target ~200 members with housing instability (not solely HUD homeless like initial pilot)
- Partner with Housing Authorities to set aside vouchers
- Pay for Success / Value-Based Arrangement w/ CHS (social service agency) – partner with Corporation for Supportive Housing on technical assistance
- Advisory Board
- ***FIRST PERSON HOUSED: JANUARY 2019***

UPMC LIFE CHANGING MEDICINE

49

49

Community-level Change: Housing Investments

Strategic Tax Credit and Other Investments to Improve our Community:

- ✓ Mixed use developments that include affordable housing
- ✓ Preservation or rehab of existing affordable housing
- ✓ Remediation of mold, lead, pests in housing
- ✓ Wrap-around services in housing
- ✓ Making housing healthier through creation or expansion of greenspace, food access, transportation, infrastructure, and access to economic opportunity

- ✓ ***Partnership with Omicelo*** – mission-driven real estate fund aiming to build out communities for current residents

UPMC LIFE CHANGING MEDICINE

50

50

Macro-level Change: Aligning for Health

- ✓ **Mission:** Energize stakeholders and the Administration on the need to test whether a more flexible federal regulatory and funding framework will allow states, counties, and other stakeholders to implement pilot programs to address the whole-person needs of Medicaid beneficiaries
- ✓ **Composition:** Health Plans, Trade Organizations, Providers
- ✓ **Goal:** Create Healthcare Performance Partnership Pilots (HP3) to allow communities to apply for demonstration programs that permit, with guardrails, the blending and braiding of funds to address social determinants of health.

UPMC LIFE CHANGING MEDICINE

51

51

Q&A Session

ACAP

52

52

More information available at:

https://www.communityplans.net/event/acap-congressional-briefing-september-13/

Thank you!

ACAP

53

53