

Public Health
Seattle & King County



Braiding EHE Funding to Address Social Determinants of Health

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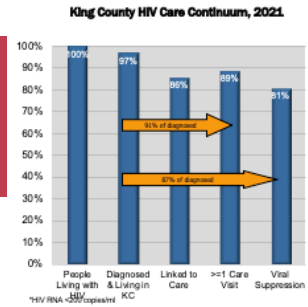
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Presentation Overview

- ▶ **Brief background**
- ▶ **Braided funding approach for our core EHE strategy**
 - ▶ **and lessons learned to date**
- ▶ **Questions later!**

Background

EHE Population: “The Last 10%”



- ▶ ~7,000 persons diagnosed and living with HIV (of ~2.27M residents)
- ▶ Our systems seem to be working well for most (90-90-90*) - but not all
 - ▶ ~200 persons undiagnosed and ~950 not virally suppressed (~500 “persistently”)
- ▶ Characteristics of “The Last 10%” (i.e. >HIV dx, <PrEP use, <VS)
 - ▶ Persons living homeless or unstably housed*
 - ▶ Persons with untreated substance use and/or serious mental illnesses*
 - ▶ Persons who are US born Black and Latinx MSM and transgender persons*

*more pronounced among those who live in South King Co (services central)

EHE Philosophy & Use



- ▶ There are valid and complex reasons (esp. SDoH) that our EHE population isn't engaged through our existing systems
- ▶ These are systems failures, not people failures. We need to change our systems to better serve this population – not keep requiring people change to meet our current systems' needs.
- ▶ Saw EHE as a once in a generation opportunity to develop the infrastructure to better serve this group
- ▶ We have an evidence based model in central Seattle: Max Clinic – incentivized, walk in HIV care
- ▶ Our core EHE strategy was to expand access to and adapt the MAX model to N. Seattle & S. King Co.
- ▶ Most other EHE activities are to help people achieve and sustain engagement with low barrier services– i.e. Mobile Outreach Team, housing readiness services, MH services, hygiene services, etc.

**Braided Funding Approach
for EHE Low Barrier Services
(and lessons learned to date)**

Context: RWPA vs EHE Planning

- Approach to planning was different for EHE than for RWPA
 - Integrated HIV prevention and care planning body
 - Focused on a smaller group of people and mostly status neutral strategies
 - Learned about the funding amounts later - tried to make it all work
 - Learned about extent of constraints to the use of those funds later - tried to make it all work
- Up side – Really were able to approach planning without the impact of prior structures and come up with and implement new, innovative strategies
- Down side – Braiding funding was challenging!

Evolution to Braided Funding for Low Barrier Services

Year 1

- Budgeted across awards based on expected HIV status of client populations/populations impacted by the strategy
- % expected to be HIV+: HRSA
- % expected to be HIV- or HIV status unknown: CDC
- HRSA Service Category: Initially EHE Initiative Services, then split across multiple after RSR attempt

Year 2

- Increasing clarity re: what of RWPA applied to EHE – made it more difficult to spend HRSA funds and changed how we needed to use the CDC funds for the intervention
- Increased awareness of the impact of funding individual services at an agency with two federal awards – esp. on smaller, new voices partners totally new to both systems
- Increased ref's to “braided funding” & joint letter that supported use of HRSA funds for status neutral activities
- Changed funding approach to fund smaller subs through one or the other award – when possible.
- This meant that some people with HIV were now funded through CDC funds and some people without diagnosed HIV were served through HRSA funds (EIS mostly)
- Made the admin, program, and fiscal pieces better for all – but some down sides, like people not captured in federal data systems siloed by HIV status

Year 3

Year 4

Yr 5+

TBD!

Example: Braided Funding for Low Barrier Services

HIV Positive – All* HRSA

All clinic services (OAMC, MCM, NMCM, MH, Housing): HRSA

Mobile Outreach Team: DRIS (HRSA) & Peer (CDC -> HRSA)*

System resource for immediate, walk-in linkage or re-linkage to HIV care or ART: HRSA

HIV Status Unknown - Braided

Visit includes/culminates in HIV Testing: HRSA EIS

Visit is “primary care lite” (wound care, STI testing, BP check, etc.) to develop trust to engage in HIV testing: CDC

PrEP, PrEP labs, PrEP navigation: CDC

System resource for immediate, walk-in linkage to testing (esp. after PH CDR): HRSA Outreach or HRSA EIS

System resource for immediate, walk-in linkage to PrEP (esp. after PH CDR): CDC



Thank you!

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Addressing Health-Related Social Needs in Section 1115 Demonstrations



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Background

- In 2021, CMS released a **State Health Official (SHO) letter** that describes opportunities to address Social Determinants of Health (SDOH) in Medicaid and CHIP.
- Core to advancing equity is addressing enrollees' **health-related social needs (HRSN)** through:
 - **Care Delivery** — Transitioning to a delivery system in which states, plans, and/or providers screen for health-related social needs and act to meet those needs
 - **Quality Measurement** — Using a consistent measurement framework to create accountability for HRSN screening and success at meeting HRSN
 - **Coverage of clinically appropriate HRSN interventions** — Covering short-term, upstream, clinically appropriate HRSN interventions
- States can address SDOH through a variety of Medicaid authorities, including **state plans, 1915(c) waivers, managed care in lieu of services (ILOS)** and **section 1115 demonstrations**. Several states, including **California, Massachusetts, Oregon, Arizona, and Arkansas**, have begun to integrate SDOH services into their state Medicaid programs through these authorities.
- In particular, some states have **used 1115 demonstration flexibilities to cover** certain evidence-based services that address SDOH, or more specifically, **health-related social needs**.
 - This option allows states to take a more **nuanced approach to defining target populations** for HRSN services than permitted through other CMS authorities
 - In order to cover HRSN services, states must agree to **additional requirements and guardrails**
 - HRSN services have **unique treatment in budget neutrality** calculations
- CMS is committed to supporting states to address HRSN, and has established a **framework to evaluate state proposals** to cover these services through 1115 demonstrations.

What are Health-Related Social Needs, and why should Medicaid address them?

- HRSN are **an individual's unmet, adverse social conditions that contribute to poor health**. These needs – including food insecurity, housing instability, unemployment, and/or lack of reliable transportation – can drive health disparities across demographic groups.
 - An individual's HRSN are **a result of their community's underlying SDOH** – the conditions in which they are born, grow, work, live, and age, and the wider set of forces and systems shaping their conditions of daily life, including economic policies and systems, development agendas, social norms, social policies, and political systems.
- Extensive research has indicated that SDOH and associated **HRSN can account for as much as 50% of health outcomes**.¹ By addressing HRSN, state Medicaid agencies can help their members stay connected to coverage and access needed health care services.
- CMS acknowledges the important links between HRSN, health coverage, and health outcomes. Therefore, we are offering an **1115 demonstration opportunity to support states in addressing HRSN**, with the goals of improving coverage, access, and health equity across Medicaid beneficiaries.

¹ <https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf>

Overview: A framework for HRSN services in 1115s



Covered Services

- Housing supports
- Nutrition supports
- HRSN case management

Note: certain other HRSN services, such as transportation to HRSN-related activities, may be allowable outside of this framework



Service Delivery

- Must be medically appropriate, as determined using state-defined clinical and social risk factors
- Must be the choice of the beneficiary, who can opt-out at any time. Cannot be required or disqualify beneficiary from other services.
- Must be integrated with existing social services (e.g., HUD services, SNAP, etc.)



Fiscal Policy

- Expenditures cannot exceed 3% of state's annual total Medicaid spend
- Infrastructure costs cannot exceed 15% of total HRSN spend
- Included in the without waiver baseline for budget neutrality purposes
- State spending on related social services pre-1115 must be maintained or increased



Related Requirements

- State Medicaid reimbursement rates for primary care, behavioral health, and OB/GYN must be at least 80% of Medicare rates, or category with lowest rates must be increased by 2 percentage points
- Systematic monitoring and robust evaluation requirements, including reporting on quality and health equity measures

Nutrition Supports

The following nutrition supports will be considered under 1115 demonstrations:

Intervention	Description
1. Nutrition counseling and education	Including on healthy meal preparation
2. Medically-tailored meals	Up to 3 meals a day delivered in the home or other private residence, for up to 6 months
3. Meals or pantry stocking	For children under 21 and pregnant individuals, up to 3 meals a day delivered in the home or other private residence, for up to 6 months
4. Fruit & vegetable prescriptions and/or protein box	For up to six months

These services should **supplement, not supplant**, existing federal, state, and local nutrition supports. State Medicaid agencies should **partner with other state agencies and social service providers** to ensure that beneficiaries experiencing food insecurity are connected to programs like **SNAP, WIC, and TANF**.²

² SNAP: Supplemental Nutrition Assistance Program. WIC: Supplemental Nutrition Assistance Program for Women, Infants, and Children. TANF: Temporary Assistance for Needy Families.

Housing Supports (1/2)

The following housing supports will be considered under 1115 demonstrations:

Intervention	Description
1. Rent/temporary housing (+/- utilities) for up to 6 months	<u>Limited to:</u> individuals transitioning out of institutional care or congregate settings; individuals who are homeless, at risk of homelessness, or transitioning out of an emergency shelter as defined by 24 CFR 91.5; and/or youth transitioning out of the child welfare system
2. Traditional respite services	Temporary, short-term relief for primary caregivers provided by an at-home provider, a health care facility, or an adult day center
3. Day habilitation programs & sobering centers	For <24 hours, no room and board
4. Pre-tenancy & tenancy sustaining services	Including tenant rights education and eviction prevention
5. Housing transition navigation services	Including individualized case management

Housing Supports (2/2)

Intervention	Description
6. One-time transition & moving costs	Including security deposit, first month's rent, utilities activation fees, movers, relocation expenses, application and inspection fees, fees to meet identification requirements, etc.
7. Medically necessary home accessibility modifications & remediation services	Including carpet replacement, mold and pest removal, and ventilation improvements
8. Medically necessary home environment modifications	As needed for medical treatment and prevention, including air conditioners, heaters, air filtration devices, and generators

Integration with state/local housing agencies

Services and supports that can assist with obtaining and maintaining housing are a top need identified by housing and homeless services agencies.

Partnerships with state and local housing agencies are essential to success in implementation of allowable housing supports under Medicaid programs.

State and local housing agencies can play three roles:

- **Coordinating the provision of rental assistance** or affordable housing to beneficiaries who are receiving tenancy sustaining services;
- **Serving as providers** of housing navigation, pre-tenancy, and tenancy sustaining services to eligible beneficiaries;
- **Administering short-term housing assistance or one-time transition and moving costs** on behalf of a state Medicaid agency.

Medicaid-covered affordable housing supports **should supplement, but not substitute** existing housing funds. Ideally, Medicaid-covered housing supports should work seamlessly with available housing resources and programs.

Identifying and partnering with state/local housing and homeless services agencies

Agency Type	Role and Programs
<p>State housing finance agencies (HFAs)</p>	<ul style="list-style-type: none"> ▪ State-chartered authorities that help finance the development of affordable housing, including administering state allocations of the federal Low Income Housing Tax Credit Program and housing bonds. ▪ Also administers HUD’s HOME Investment Partnerships and Section 811 Supportive Housing Program for people with disabilities.
<p>Public housing authorities (PHAs)</p> <p>3,000+ that function statewide or cover a county/metro or municipal catchment area</p>	<ul style="list-style-type: none"> ▪ Oversees and manages federal public housing. ▪ Administers Housing Choice Vouchers and special purpose voucher (rental assistance) programs. ▪ Some also directly develop affordable housing.
<p>Municipal and county government housing agencies</p>	<ul style="list-style-type: none"> ▪ Helps finance the development of housing. ▪ Administers federal housing capital programs like HOME, CDBG, as well as local housing resources.
<p>Continuum of Care</p> <p>~380 Continuum of Care communities that coordinate homeless services at the city, county, or regional levels</p>	<ul style="list-style-type: none"> ▪ Coordinate the use of federal homeless assistance grants (Continuum of Care Program grants) ▪ Coordinate homeless services programs and delivery, including through coordinated entry systems ▪ Collect and report administrative data on homeless population

Key Issues and Considerations

- Timing is everything. Until recently, most housing and homeless services agencies have been experiencing resource scarcity for rental assistance. Through the American Rescue Plan and FY 2022 appropriations, housing and homeless services agencies have experienced an influx of new resources.
- Coordinate eligibility for allowable housing supports with existing processes and systems for determining eligibility and prioritization for housing and homeless services (e.g., waiting lists and coordinated entry systems). Housing agencies typically cannot prioritize people on the basis of diagnosis or disability.
- Align short-term housing assistance with existing long-term rental assistance program requirements and processes. For example, Medicaid-covered short-term housing assistance can be administered in ways that mirrors Housing Choice Vouchers.
- Communication and collaboration require an ongoing process. An investment of time and effort to plan, implement, monitor, troubleshoot, and modify processes will increase chances of success.

Covering other HRSN services in 1115s

- CMS may consider services beyond those in the HRSN 1115 framework on a **case-by-case basis**. Other HRSN services may require different treatment for budget neutrality calculations.
- States interested in covering other HRSN services should work with their project officers to explore options within their 1115 demonstrations.

Service delivery requirements for HRSN services

- All HRSN services must be **medically appropriate**, as determined using state-defined clinical and social risk criteria. Individuals receiving HRSN services must have a **documented need for the services** in their care plan or medical record.
- HRSN services must be the **choice of the beneficiary**, who can opt-out at any time. States/managed care plans cannot condition Medicaid coverage or coverage of any benefit or service on the receipt of HRSN services, nor do HRSN services absolve the state or managed care plans from providing other medically necessary services.
- States must have **partnerships with other state and local entities** (e.g., HUD Continuum of Care Program, local housing authorities, SNAP state agency) to assist beneficiaries in obtaining non-Medicaid funded housing and/or nutrition supports.

HRSN fiscal policy

CMS has implemented specific fiscal policies for HRSN services:

- Spending cap: A state's annual **HRSN expenditure authority** (services + infrastructure) **cannot exceed 3%** of their total annual Medicaid spend.
 - Limited federal expenditure authority for **HRSN infrastructure** may be considered, but **will not exceed 15%** of the state's total HRSN expenditure authority.
- Budget neutrality: HRSN services and infrastructure expenditures will be **included as “Without Waiver” expenditures** in budget neutrality calculations. States will not be required to offset these expenditures with budget neutrality savings and will not be permitted to accrue savings if actual expenditures are lower than expected.
 - Note: At this time, any HRSN services approved outside of the CMS framework will be included as “With Waiver” expenditures and require a savings offset.
- Maintenance of effort for related social services: States must **maintain a baseline level of state funding for social services related to their approved HRSN services**. This baseline must be developed in collaboration with CMS and updated in annual monitoring reports.

Other HRSN-related 1115 requirements (1/2)

Provider Reimbursement Rates: As states increase their investments in services to address HRSN, CMS also expects states to ensure provider rates are sufficient to ensure access to basic Medicaid services.

If state's proposed annual HRSN expenditure authority equals at least \$50M or 0.5% of the state's total annual Medicaid spend (whichever is less), they must meet the following requirements:

- The state's **Medicaid-to-Medicare rate ratios must be at least 80%** for **primary care, behavioral health, and OB/GYN services**. This must be measured separately for fee-for-service and managed care delivery systems, for a total of six ratios.
- States that cannot fulfill this requirement with their existing rates must commit to **increasing rates by 2 percentage points** in their lowest-performing category across any delivery systems <80% (FFS, managed care, or both). This rate increase must be implemented by the start of demonstration year 3 and be sustained throughout the demonstration.

Other HRSN-related 1115 requirements (2/2)

Monitoring and Evaluation: Similar to other 1115 demonstration authorities, HRSN services are subject to systematic monitoring and robust evaluation processes:

- In order to help identify key quality and equity gaps in state Medicaid programs, states must submit reporting to CMS on: HRSN service **implementation**, including progress made and any challenges experienced; HRSN service **utilization**; **quality** of services; and **health outcomes** for individuals receiving HRSN services.
- Evaluation must test whether HRSN services (1) **effectively address unmet HRSN**, (2) **reduce potentially avoidable, high-cost services** (e.g., ED visits, institutional care), and/or (3) **improve physical and mental health outcomes** for beneficiaries.
- State must also commit to **reporting on a slate of CMS health equity metrics** (to be defined), **stratified by race/ethnicity, language, geography, disability status, sexual orientation, and/or gender identity**. CMS will work with states on a case-by-case basis to determine feasibility of different stratifications; all states will be required to stratify across at least some of these dimensions.

Appendix: Identifying and partnering with housing and homeless services agencies

Useful links to find state and local housing agency partners:

- **State housing finance agencies** – The National Council of State Housing Agencies maintains a list of state HFAs: <https://www.ncsha.org/membership/hfa-members/>
- **Public housing authorities** – HUD maintains a list of public housing agencies and their contacts: https://www.hud.gov/program_offices/public_indian_housing/pha/contacts
- **Municipal or county housing agencies** – No single list. HUD municipal or county housing agencies can be found by searching for ‘CDBG’ and ‘HOME’ grantees by state: <https://www.hudexchange.info/grantees/#/byState>
- **Continuums of Care** – The lead agency for each Continuum of Care, also known as a ‘Collaborative Applicant,’ can be found by searching for ‘Continuum of Care’ grantees by state: <https://www.hudexchange.info/grantees/#/byState>