# Maximizing Foundational Community Supports in King County: Phase I Report to the King County Regional Homeless Authority

## Background

The King County Regional Homelessness Authority (KCRHA) has launched Partnership for Zero, an initiative to dramatically reduce unsheltered homelessness, starting in downtown Seattle and expanding to a set of regional communities. The goal of the initiative is to build a future where homelessness is rare overall and brief when it occurs, by combining resources and investing in targeted infrastructure and capacity to put every person who is experiencing unsheltered homelessness on the path toward permanent housing.

Foundational Community Supports (FCS) is the name of two Medicaid benefits designed to address the social determinants of health: housing, and employment. The FCS supportive housing services benefit pays service providers to deliver pre-tenancy and tenancy-sustaining services to people experiencing chronic homelessness and other health challenges and housing instability. The Authority sees FCS as a critical element of the needed targeted infrastructure to end homelessness because these services are essential components to helping people who experience homelessness regain housing stability, and the homeless system will never have the resources to invest in these services at the scale they are needed.

In contrast to traditional revenue sources for services, Medicaid provides an ongoing revenue stream that can significantly increase income for providers, allowing them to pay professional wages and serve far more people. Medicaid is funded by the federal and state governments and, if leveraged locally, would support the Authority, other local governments, and communities across King County in meeting their goals to address homelessness.

Over the past six years, providers in King County have begun to learn to use FCS and integrate Medicaid to serve people experiencing homelessness. Today, twenty-six organizations in King County are part of the FCS program for both employment and supportive housing. Many providers see the potential that FCS can bring to the community and most report optimism about the vision for the program. While this is an important start, significant untapped potential remains in the healthcare system's interest and ability to pay for tenancy support services.

CSH is working in other states to promote the utilization of Medicaid to address Health Related Social Needs and Social Determinants of Health and has been a long-time supporter of FCS. KCRHA contracted with CSH to 1) assist the authority in becoming eligible to seek Medicaid reimbursement for its peer navigators/system advocates, and 2) explore the challenges and barriers providers report in utilizing FCS as a basis for addressing these barriers in Phase II of KCRHA's effort to maximize FCS in King County.

Part 1 of this report summarizes the Authority's progress in becoming eligible to seek Medicaid reimbursement directly, and Part 2 provides detailed insights into challenges of utilizing FCS based on CSH's extensive interviews with providers who are currently using FCS and organizations led by and for

primarily Black, indigenous, and other people of color who are interested in FCS but not part of the program. Supporting FCS means adjusting and making improvements as needed to assure it is reaching the people who need the services.

## Part 1 – KCRHA Becoming Medicaid FCS Provider: Summary of Accomplishments

To assist KCRHA in becoming a Medicaid FCS provider, CSH worked alongside the KCRHA program managers from August through December and together accomplished the following.

- Confirmed KCRHA met the eligibility to become a Medicaid FCS provider agency
- Confirmed KCRHA peer navigators or system advocates met the qualifications for providing FCS services
- Reviewed program components required for being a Medicaid FCS provider agency
- Shared multiple resources to support the program knowledge and implementation of Medicaid and FCS
- Set realistic timeline for implementation
- Clarified roles within KCRHA to meet the Medicaid FCS program requirements, including Finance, Billing, Data, Program Outcomes, and Program Training and Supervision
- Utilized CSH's Budget Tool to forecast revenue and caseloads
- Developed business process map to detail action steps from enrollment to billing practices
- Convened regular meetings across KCRHA to assure coordination and readiness of each team
- Connected shadowing experience between KCRHA finance billing process and current FCS provider agency
- Shared required documentation training and materials for documenting in each enrolled individual record (assessment, support and care plan, and progress notes for each date of service)
- Searched and identified system advocate training that centers housing first perspective

***Current status:*** KCRHA has made critical progress in its efforts. CSH and KCRHA staff estimate that it will begin requesting Medicaid reimbursement for its efforts in the summer of 2023. As a direct provider, KCRHA will continue to work with CSH on the process of "warm hand-offs" with other providers.

## Part 2- Research on Challenges and Barriers to Maximizing FCS: Summary Themes and Recommendations

This portion of CSH's report describes information learned from conducting interviews with the current Medicaid FCS providers in King County and organizations led by and for Black, indigenous and other communities of color who are not currently Medicaid FCS providers but might be interested in the program. There are collaborative solutions to every barrier listed below. The effort to reach those solutions will require reliable and current data on social needs, talking directly with people who are experiencing homelessness, partnering with and listening to providers, and collaboration among providers and systems. These efforts are needed to support supportive housing providers. Major themes and proposed recommendations for Phase II are captured as a result of those interviews.

Interviews consisted of the following questions.

- Are you maximizing FCS for the population you serve and if not, what are issues preventing your agency from maximizing or using FCS?
- What solutions or ideas do you have that would improve FCS access and availability in King County?
- What types of grants and/or TA would be helpful to scale FCS at your agency/organization?

## Theme 1: Administrative Barriers

***1. Manual Entry for Billing*.** All but two providers are manually entering client information into Amerigroup's billing system in order to receive payment. With the FCS daily rate per individual, this is time consuming administrative work that requires tracking and budgeting which is different than the grant-based funding requirements providers are accustomed to. Many of the providers were new to Medicaid, and if they were not new to Medicaid, they were new to the specific way in which claiming and billing for Medicaid occurs for FCS. **The manual entry creates additional administrative work that many providers did not anticipate and providers new to FCS report not having the internal capacity to support.**

Amerigroup's billing system is called Availity. Availity is optional for providers to use, however many use it because it is offered free to them. **Most providers also store client data in a separate electronic health record (EHR) and in HMIS then enter a third time manually in Availity.**

Availity does not accept the EHRs from providers or any reports from HMIS systems that export to Availity. Availity is a standard way for Amerigroup to accept billing or claim information, but it has not benefitted providers directly.

*2.* ***Online Initial Assessments and Client Tracking.*** Tracking client information and billing claims is the responsibility of the FCS provider. This starts with the initial assessment and ends with payment to the provider. The initial assessment form is an online form required by Amerigroup that contains all of the required Medicaid information except for accompanying documents to demonstrate the individual meets the eligibility criteria. Prior to Amerigroup introducing this online version, providers were able to send the assessment together with the related documents all together. This was easier for providers because all documents were contained in one email and it allowed them to have a centralized way of tracking this documentation.

**Because the assessment is now online but the additional required attachments are required to be sent separately from the initial assessment, frequent emails are often needed back and forth between Amerigroup and the provider to assure Amerigroup has all the information needed to determine an individual's eligibility for FCS services.**

Tracking what was sent and when it was sent is all necessary and critical information not just for eligibility but also for reconsidering denials and disenrollments. If there is a denial or disenrollment (more information in Theme 2 below), providers have certain time frames for requesting reconsideration or appeals. The current approach leads agency providers to work extra hours to track information and eventually leads to lower numbers of individuals enrolled and utilizing FCS. It is also loss revenue for the providers because of the added time it takes to track this information manually.

Many FCS providers do not have the staffing and infrastructure to manually enter and track this much information. **Organizations led by and for Black, indigenous and other communities of color who are not currently Medicaid FCS providers are aware of the documentation and tracking requirements, and some shared that it was a factor that prohibits them from becoming a Medicaid FCS provider.**

Other areas providers shared that would be helpful to align and automate include eligibility determinations, service authorization dates, metric reports, templates for progress notes.

**CSH Recommendations for Phase II:**

1. Provide funding for a county-wide data enabled collaboration system to assist housing providers with connecting client information to the Amerigroup billing system and to a tracking system from start to finish (payment received).
2. Convene a series of sessions with current and prospective FCS providers to establish the technical requirements for this to work.

## Theme 2: Denials/Challenges with Eligibility Determination and Disenrollment

Everyone wants FCS to reach the people who need these services. However, providers report large numbers of denials and individuals disenrolled in FCS. Providers see first-hand the individuals who really need FCS services that are being denied or not enrolled. This is frustrating for them and leads to not reaching the people who need the services. **Many providers stated that the risk of not being reimbursed for the work of enrollment is too high for them to rely on FCS right now.**

Denials are different than disenrollments.

1. ***Denials.*** Denials are when a provider submits an initial assessment to enroll an individual in FCS, and Amerigroup determines the person does not meet FCS eligibility requirements. When Amerigroup's FCS team determines a person's eligibility for FCS, they apply the eligibility criteria in the State's 1115 Waiver that was approved by the State and the Federal Centers for Medicare & Medicaid Services (CMS).

An individual is eligible for FCS if they have at least one health need and at least one housing risk factor. **The health need may be determined by** a licensed behavioral health agency, the Department of Social and Health Services' Long-Term Services and Support assessment, or **a coordinated entry assessment. The risk factor must be approved by a qualified professional.**

**Health need (must select at least one)** [1]
**The client meets one of the following criteria:**

☐ 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 (as determined by a licensed behavioral health agency).

[1] Copied from Amerigroup FCS Assessment Form, WAPEC-3318-21, January 2022, https://provider.amerigroup.com/WA

☐ Diagnosed with a substance use disorder (SUD), as determined by meeting a one or higher level on the American Society of Addiction Medicine (ASAM) Criteria (as determined by a licensed behavioral health agency).

☐ Needs assistance with three or more activities of daily living (ADL) or one or more hands-on ADL as determined by a Comprehensive Assessment and Reporting Evaluation (CARE).

☐ The client is a homeless individual with a disability, determined by a coordinated entry assessment. (Individual assessed to have a complex health need, which is defined as a long continuing or indefinite physical condition requiring improvement, stabilization, or prevention of deterioration of functioning including ability to live independently without support)

**Risk factors (to be approved by a qualified professional; must select at least one risk factor):**

☐ Chronically homeless: an individual with a disabling condition who has been homeless for a period of at least one year, or an individual with a disabling condition who has had at least four episodes of homelessness, as long as the combined occasions equal at least 12 months.

☐ Frequent or lengthy institutional contacts (frequent, as in two or more instances in the past 12 months, or lengthy, as in lasting 90 days or more)

Is the client transitioning out of an institutional setting? ☐Yes ☐No

If yes, select all that apply:

☐ Nursing

☐ Inpatient psychiatric hospital

☐ Inpatient medical hospital

☐ Correctional program or institution

☐ Foster care facility or other youth facility

Has the client resided within one of the previously listed institutional settings multiple times in the past year? ☐ Yes ☐ No

If yes, number of times:

☐ Frequent residential care stays (two or more occurrences in the past 12 months)

Has the client resided within a residential care facility two or more times in the past 12 months?

☐ Yes ☐ No

If yes, select all that apply:

☐ Evaluation and treatment facility

☐ Inpatient substance use treatment facility

☐ Detox center

☐ Adult residential care, assisted living, or adult family home (AFH)

☐ Frequent turnover of in-home caregivers (three or more occurrences in the past 12 months)

Has the client experienced frequent turnover of in-home caregivers? ☐ Yes ☐ No

Within the last 12 months, has the client used three different in-home caregiver providers? ☐ Yes ☐ No

☐ PRISM predictive risk score 1.5 or above (contact the TPA, MCO, BHO, Health Home, or HCS case manager to obtain the PRISM risk score)

Several providers state that many denials (approximately half of the denials) are system technical errors that take time to research and report back to Amerigroup. The volume of denials is time consuming and costly for providers.

Housing providers have view-only access to Provider One which is the Apple Health (Washington's name for its Medicaid program) provider enrollment and client billing system. They view Provider One routinely to check an individual's Medicaid eligibility and FCS enrollment. Housing providers can see the errors in Provider One. They report the errors, they provide the appropriate documentation to support the corrections, and then they wait for the corrections to occur.

Another reason for denials stated by the providers is the Behavioral Health diagnosis which takes time and resources (some housing providers are behavioral health agencies, and some are not). **If an individual is not homeless as determined by the coordinated entry and has not been seen or is not known in the Behavioral Health system and has not completed a Long-Term Services and Supports (LTSS) assessment for activities of daily living, then they are denied FCS.**

Because eligibility determinations are not streamlined and easily determined up front, providers report attempting to use the state's predictive risk intelligence system measurement (PRISM) scores to determine eligibility. This eligibility criterion for FCS was designed to ensure individuals who do not actively meet eligibility criteria can still be eligible for FCS if they have the risk conditions to suggest they will be eligible in the future if they do not receive these services. **This is an inefficient approach to eligibility determinations for people who providers know first-hand are clearly and currently eligible for FCS.** Access to PRISM is also not easily available to providers. Amerigroup can check PRISM scores and behavioral health diagnoses if the individual has a PRISM score or is known to a behavioral health organization. Using this approach leads to a number of denials that cause additional uncompensated administrative work.

Additional research is needed about the causes of denials to clarify what is causing the denials and disenrollments and inform an allowable and streamlined process for getting the right information from the providers to Amerigroup – a more streamlined, approved approach for determining eligibility.

**A couple of the current FCS providers and most organizations led by and for primarily Black, indigenous, and other people of color reported being cautious about enrolling in FCS because of the impact to their current services and the labor-intensive work around determining eligibility and billing for their services.**

2. ***Disenrollment.*** Amerigroup has a team referred to as their Cost Containment group, which determines disenrollments. Amerigroup's Cost Containment group is structurally separate from their FCS team. Disenrollments are when Amerigroup's FCS team approves an individual as eligible for FCS then later the Cost Containment group determines the individual was not eligible. Because the provider was initially approved to serve the individual, Amerigroup starts reimbursing them for services. **When the Cost Containment group later disenrolls them, the provider has to re-pay Amerigroup.**

**Disenrollments are having a "chilling" effect on utilization of FCS.** Providers are concerned about when or how often disenrollments will occur and whether they will have enough savings to re-pay Amerigroup. As a result, senior leadership, finance Directors, and Boards are seeing the financial risk as greater than the financial benefit of this revenue source.

**CSH Recommendations for Phase II:**

1. Complete further research on denials and disenrollments. Develop more detailed findings and recommendations supported by the research on ways to improve the rate of denials and disenrollments, including any recommendations for streamlining the eligibility determination process so that FCS is reaching the population who most need this service. Share these recommendations with the State and Amerigroup and engage them in working sessions to address them together with providers.
2. Determine how the Coordinated Entry system could ensure a qualified professional is available to make health eligibility determinations.

## Theme 3: Supplementing Service Funding Gaps

Many providers started FCS with the hope that these additional funds would help fill gaps in their services funding and allow them to serve more people. The federal Medicaid program has long-standing rules about the ways other sources of funding can supplement Medicaid reimbursements and prohibitions on Medicaid supplanting other funds. A good deal of confusion exists about these parameters because specific guidance is not available about how to put these principles in practice.

The Health Care Authority and Amerigroup provide a one-page information sheet on supplementing services. However, there is no specific direction on how providers can operationalize the FCS funding to supplement and fill service gaps. *"FCS can serve people who are receiving minimal housing case management services (such as Housing and Essential Needs participants) whose housing stability and health would benefit from receiving FCS supportive housing services. In this case, the individual must meet FCS eligibility criteria and be authorized by the Amerigroup Third Party Administrator (TPA) before receiving FCS services. This is not supplanting resources because FCS is not replacing comparable services; rather, FCS is enhancing services that are not adequately meeting the participant's needs."*[2]

**The lack of clarity about how to supplement funds without supplanting them has led some providers to limit their use of FCS to small, discreet programs rather than making it available to everyone they serve who is eligible.**

CSH's work in King County and around the country indicates the timeliness and importance of clarifying this for providers. Our initial research suggests that the requirement to prevent supplantation lies at the system level rather than the provider level. The new CMS Medicaid 1115 Waivers in other states all have language requiring states to 1/ coordinate the use of federal housing funds with the Medicaid funds; and 2/ maintain or increase state spending on related services that existed prior to the waiver being approved (also called Maintenance of Effort). The MOE in effect requires States, and therefore providers, to not supplant funds but to supplement.

[2] WAWA_CAID_STATEFCSResourcesupplanting.pdf (amerigroup.com)

Clearly, existing local and state funds for services are insufficient to serve everyone in need, but defining what and how supplementing can work is important to giving providers the confidence to maximize available funding to serve everyone who is eligible.

**CSH Recommendations for Phase II:**

1. Research and develop guidance to providers and systems about ways to supplement other services funding to better serve everyone in need.
2. Work with the Health Care Authority, Department of Commerce, and regional and local funders of services to clarify these rules in a way that maximizes and streamlines local, state and federal funds to serve everyone in need.

## Theme 4: Uncovered Costs

Recruitment, hiring, training staff and purchasing IT systems are all required well in advance (at least six months) of receiving FCS Medicaid reimbursement. Amerigroup and the Health Care Authority provide technical assistance and training at no cost to providers and in some cases, they also provide small grants for start-up costs. **Once providers are up and running with Medicaid FCS, it is projected to cover gaps with increase revenue, but to get to that point, providers report their start-up costs to be far more than they can afford, in some cases in the hundreds of thousands of dollars.**

FCS providers and service organizations also reported uncovered costs relating to enrolling and completing Medicaid applications for individuals, or when the client does not show for a meeting time but the provider has reserved that time for them, or the administrative costs for billing/claiming Medicaid. Organizations led by and for primarily Black, indigenous, and other people of color reported several areas of uncovered costs. For example, traditional healing services they offer would not be covered.

Providers who also operate housing also cited the "nature of the work" of delivering services and running housing that are not covered by the FCS rate because many costs continue whether they have an FCS billable service or not. Providers currently combine their flexible services funding with operating dollars to cover the operations costs of managing buildings and the milieu of residents within a building. They report needing more clarity on the eligible uses of operating and services funds to ensure the full costs of building operations and flexible services supports are still available when maximizing FCS.

**CSH Recommendations for Phase II:**

1. Provide grant funding for FCS providers to cover up-front expenses related to administering and scaling utilization of FCS.
2. Assist state and local funders in creating parameters for blending State-only funds with Medicaid funds to cover costs and clarifying guidelines on which State funds cover operating vs services.

## Theme 5: Communication and Payments

1. ***Notices and comment periods.*** Notices and comment periods for changes to FCS occur routinely by Amerigroup, most likely as an effort to continually improve and meet requirements. Providers report not having advance notice of these changes, not having the opportunity to comment on

the changes beforehand, and/or not being able to realize the impact of the changes until after they have been implemented. Often, changes cost providers funding to implement because the change often results in providers having to make administrative changes that they are not set up to do. The changes can also lead to lower billing or utilization with providers just not able to implement the changes.

2. ***Rate changes that cover expenses.*** Increases in costs of living and rising inflation have affected providers' ability to recruit and retain staff and their ability to provide FCS services in King County. Workforce shortages are significantly impacting all providers. There has been one increase in the FCS rate since it started in 2018, from $105 per individual per day to its current rate of $112 per individual per day. There was a temporary enhanced rate during COVID of $134 per individual per day.

The Health Care Authority has requested funding to conduct a rate study through a contract with Mercer (office locations in Seattle and Spokane). Their request was included in a supplemental decision package for SFY 2021. Mercer will study the actual provider costs for FCS then HCA will propose rate adjustments in the following year's budget session. This means it could be July 2023 (or likely July 2024) before providers see a rate increase if the rate study is completed timely. It will be important that the providers show the uncovered costs of FCS and that HCA structures the rates in a way that covers the costs, and it could be helpful to have local funding to support providers until this change occurs.

3. ***Warm hand-off expenses between providers***. There are times when eligible individuals transition from one FCS provider to another. Medicaid will only pay for one provider at a time for the same service, but this transition takes time and funding to execute in a way that is supportive to the individual being served.

One example is when one FCS provider worked with an eligible individual for quite some time before the individual was housed with another FCS provider. The individual reached out to the first provider where an established relationship existed. The first provider submitted a claim to bill for FCS services but was denied because the second provider was providing FCS services to the individual since the first day of admission to their building. The closing of that individual's case with the first provider took time as the first provider assured the second provider had the information to make the transition smooth for the individual.

**CSH Recommendation for Phase II:**

1. Facilitate dialogue between providers, Amerigroup, and HCA to develop a formal advance notification and comment period for changes to FCS.
2. Track the rate study and inform it with information collected from providers and examples using CSH's services budgeting tool.
3. Support the state in creating an approach to braiding state-only funds with Medicaid funds to cover the full costs of providing tenancy supports in King County.