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CalAIM Team
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Re: Comments on CalAIM for Medi-Cal Beneficiaries Experiencing Homelessness

Dear Mr. Lightbourne, Ms. Cooper, and the Enhanced Care Management and In Lieu of Services Team—

On behalf of the above organizations, who work to promote the health and stability of Californians experiencing homelessness, we are writing to offer comments and recommendations on the California Advancing & Innovating in Medi-Cal (CalAIM) proposal released in January 2021, as well as the draft requirement documents for the Enhanced Care Management (ECM) benefit and In Lieu of Services (ILOS), released on February 16, 2021.

As articulated in the CalAIM proposal, homelessness dramatically impacts health outcomes and access to care. In a January 2021 State Health Official letter, the Centers for Medicare and Medicaid Services (CMS) acknowledged a growing body of evidence shows social determinants of health, including homelessness,

lead to poor health outcomes.[1] People experiencing homelessness incur Medi-Cal costs that are two to three times the costs of other beneficiaries, with the top 10% of homeless beneficiaries incurring costs in excess of $75,000 per year.[2] Despite this high level of healthcare spending, people experiencing homelessness die, on average, 25-30 years younger than housed people with similar health conditions.[3] Even before COVID-19, Californians died on the streets every day from causes directly attributable to homelessness.[4]

The CalAIM proposal also rightfully acknowledges that housing support services reduce Medicaid costs. Indeed, 30+ years of evidence and experience prove housing support services that use evidence-based approaches help people access housing and maintain housing stability. In turn, housing stability dramatically improves health outcomes and avoids and reduces per-beneficiary Medicaid costs.[5]

Because **housing support services are essential** for beneficiaries experiencing homelessness to access meaningful care, as acknowledged in the CalAIM proposal, **these services should be funded through a benefit:**

- **Housing navigation and tenancy transition services** to meet beneficiaries where they are, form trusting relationships, engage beneficiaries to want to participate in services, connect beneficiaries to local homeless systems, assess beneficiaries' preferences for and barriers to living in the community, assist beneficiaries with housing search and completion of housing applications, connect beneficiaries to landlords willing to rent to people with subsidies, help beneficiaries review and sign leases, ensure housing is safe and ready for move-in, and assist beneficiaries in arranging for move-in through moving and transportation expenses**.**
- **Housing deposits** to help people move into and stabilize in housing, including one-time costs of housing move-in, like security deposits, payment of utility arrears, and essential furnishings.
- **For those with significant barriers to housing stability, tenancy sustaining services,** to help beneficiaries stabilize and maintain housing stability, connect people with community-based resources, plan for housing support, identify and intervene in behaviors that may jeopardize housing stability, educate and train in landlord-tenant responsibilities and relationships, provide non-medical transportation, provide evidence-based employment services, and offer individualized case management and care coordination.[6]

Housing support services relate to each other: housing navigation leads to needing move-in assistance which, for certain beneficiaries, leads to needing tenancy support services. If any one of these services is

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[1]Centers for Medicare & Medicaid Services. State Health Official Letter, #21-001. *Opportunities in Medicaid & CHIP to Address Social Determinants of Health (SDOH).* Jan. 7, 2021.

[2]*See, for example,* Katherine A. Koh, Melanie Racine, Jessie M. Gaeta, et. al. "Health Care Spending And Use Among People Experiencing Unstable Housing in the Era of Accountable Care Organizations." *Health Affairs.* Vol. 39, No. 2. Feb. 2020. Health Care Spending And Use Among People Experiencing Unstable Housing In The Era Of Accountable Care Organizations | Health Affairs; Joel C. Cantor, Sujoy Chakravatry, Jose Nova, et. al. "Medicaid Utilization and Spending Among Homeless Adults in New Jersey: Implications for a Medicaid-Funded Tenancy Support Services." *Milibank Q.* Vol. 98, No. 1. Mar. 2020; Daniel Flaming, Patrick Burns, Gerald Sumner. "Getting Home: Outcomes from Housing High Cost Homeless Hospital Patients." *Economic Roundtable*. Sept. 2013.Economic Roundtable | Getting Home (economicrt.org).

[3]Carol Caton Et Al., Nati'l Symposium On Homelessness Research, Characteristics And Interventions For People Who Experience Long-Term Homelessness (2007), *available at* http://aspe.hhs.gov/hsp/homelessness/symposium07/caton/index.htm; Margot Kushel, M.D., Associate Professor of Medicine in Residence, UC San Francisco, Testimony to Legislative Forum on Homelessness in California, Jul. 18, 2007, *available at* http://www.housingca.org/resources/Joint_Ctte_on_Homelessness_Testimony_Kushel.pdf.

[4] Harriet Blair Rowan. "Homeless Deaths Surge in Los Angeles County." *California Healthline*. Apr. 2019.

[5]*See, for example*, Maria Raven, K. Doran. "An Intervention to Improve Care & Reduce Costs for High-Risk Patients with Frequent Hospital Admissions: A Pilot Study." *BioMed Central Health Services Research.* 2011; Mary Larimer, Daniel Malone. "Health Care & Public Service Use & Costs Before & After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems." *Journal of American Medical Association.* 2009; Laura Sandowski, Romina Kee. "Effect of Housing & Case Management on Emergency Room Visits and Hospitalizations Among Chronically Ill Homeless Adults." *Journal of American Medical Association* (2009); Karen Linkins, Jennifer Brya. *Frequent User of Health Services Initiative, Final Evaluation* (2008).

[6]Identified as eligible Medicaid-funded services in the State Health Official Letter, #21-001.

unavailable, the beneficiary can lose their housing and their health can decompensate. Keeping a beneficiary stably housed is less expensive than for that beneficiary to cycle in and out of homelessness.

Given this background, we offer the following recommendations to ensure beneficiaries experiencing homelessness can access housing support services in a meaningful way:

Create a Benefit to Fund Housing Support Services, Rather than Serve Beneficiaries Experiencing Homelessness Through Enhanced Care Management & "In Lieu of Services"

We agree with the goals of ECM to provide, "a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-cost and/or high need Members" through providers who offer a "community-based, interdisciplinary, high-touch, and person-centered" approach. However, ECM, as proposed, will not address the whole person care needs of people experiencing homelessness because ECM will only fund care coordination. Care coordination for beneficiaries who are experiencing homelessness is unsuccessful in reducing costs or improving health outcomes. Indeed, studies show emergency department visits, inpatient days, and costs among beneficiaries experiencing homelessness continue to increase so long as a beneficiary remains homeless, even when they are receiving intensive, quality care coordination services.[7] Similarly, ILOS, as optional services that can be added or ended, are unlikely to result in any ongoing, scalable funding for housing support services. While both the Whole Person Care and Health Homes Programs offered funding for housing support services as part of an integrated package of services, designed to address the whole needs of each beneficiary, CalAIM instead proposes to offer the most important component of these programs for people experiencing homelessness—housing support services—as optional, and allow plans to design or limit them as they see fit. For these reasons, we fear the ECM and ILOS approaches will be ineffective for beneficiaries experiencing homelessness.

Because study after study shows housing support services are highly effective in reducing Medicaid costs and health outcomes for people experiencing homelessness,[8] we recommend instead funding a benefit specifically for people experiencing homelessness and for formerly homeless supportive housing residents. A benefit should fund housing support services on a supplemental per person, per month rate, through providers with experience successfully housing people experiencing homelessness through evidence-based approaches. These services incorporate care coordination/management, while ensuring beneficiaries obtain the housing supports they need to access and maintain health stability. Beneficiaries experiencing homelessness have highly unique needs, and a benefit should address their specific challenges.

The recent CMS State Health Officer letter encourages states to use existing Medicaid authorities to fund high-quality services that are sufficient in amount, duration and scope to reasonably achieve their purpose. The letter describes ways in which states can fund services to help beneficiaries secure housing, housing and

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[7]Karen Linkins, Jennifer Brya. *Frequent User of Health Services Initiative, Final Evaluation* (2008); E. Latimer, D. Rabouin, et. al. "Cost Effectiveness of Housing First Intervention with Intensive Case Management Compared with Treatment as Usual for Homeless Adults with Mental Illness." *J. Amer. Medical Assoc.* Aug. 21, 2019; M. Larimer, D. Malone, et. al. "Health Care & Public Service Use & Costs Before & After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems." *J. Amer. Medical Assoc.* Apr. 1, 2009.

[8] Joel C. Cantor, Sujoy Chakravatry, Jose Nova, et. al. "Medicaid Utilization and Spending Among Homeless Adults in New Jersey: Implications for a Medicaid-Funded Tenancy Support Services." *Milibank Q.* Vol. 98, No. 1. Mar. 2020; E. Latimer, D. Rabouin, et. al. "Cost Effectiveness of Housing First Intervention with Intensive Case Management Compared with Treatment as Usual for Homeless Adults with Mental Illness." *J. Amer. Medical Assoc.* Aug. 21, 2019; Sungwoo Lim, Qi Gao, Tejinder P. Singh, et. al. "What Do Medicaid Spending Patterns Reveal About the Impact of Supportive Housing." *Housing Matters, Urban Institute*. 2018; M. Larimer, D. Malone, et. al. "Health Care & Public Service Use & Costs Before & After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems." *J. Amer. Medical Assoc.* Apr. 1, 2009; Karen Linkins, Jennifer Brya. *Frequent User of Health Services Initiative, Final Evaluation* (2008).

tenancy supports, non-medical transportation, and individualized supported employment services, which could all be offered in a single benefit. The letter identifies potential Medicaid authorities to fund these services, including waivers under Section 1905(a)(13), 1915(b)(3), or Section 1915(c), or a Section 1915(i) State Plan Amendment by adding housing-related services through alternative payment models, including a supplemental rate.[9] Indeed, at least 15 states, including a number of rural states, are now funding or planning on funding housing support services through a benefit offered to all experiencing homelessness, administered through a set of standardized guidelines. These states are using either a 1915(i) State Plan Amendment or 1115 Waiver *(see Appendix for a list of state action).*

Unlike ECM, which does not propose funding the above services, and ILOS, which is not a benefit, a statewide benefit with a supplemental per person, per month rate as part of CalAIM would—

- Allow the state to standardize the services interventions based on evidence-based housing support services practices,
- Avoid adverse selection by creating a mandated benefit available to all beneficiaries in a single county,
- Avoid problems of churn in connecting beneficiaries to services they need, as a single plan would not determine whether a beneficiary can access services,
- Attract providers with successful experience helping people get and stay housed, with certainty that the benefit will be available and remain in place, so long as a beneficiary needs the services,
- "Scale up" supportive housing and other evidence-based homelessness interventions, consistent with the Administration's priorities to reduce homelessness and foster Homekey success,
- Tap into and further develop the capacity of managed care plans and providers,
- Help managed care plans identify people experiencing homelessness and access housing for members experiencing homelessness, and
- Provide for future opportunities to coordinate Medi-Cal funding for services with housing made available through homeless systems. The state, for example, could align eligibility for the benefit and eligibility for state-funded housing projects, and provide plans with assistance aligning services and county-, state-, or federally-funded housing subsidies through a benefit.

In implementing a benefit, we recommend the following design:

- Offering a separate, specialized benefit that meets the unique needs of beneficiaries experiencing homelessness through a per member, per month supplemental payment as part of CalAIM,
- Requiring plans to contract with counties, homeless continuums of care, and community-based organizations with deep experience and expertise ***in providing these services*** to, rather than just experience serving, people experiencing homelessness. We saw in the Health Homes Program that even community clinics with deep health care expertise serving people experiencing homelessness often struggled to provide housing navigation and tenancy transition and support services. These providers often had difficulties even finding and enrolling these beneficiaries into the program.[10]

Change the ECM/ILOS Requirements Documents

[9] State Health Official Letter #21-001.

[10] Nadereh Pourat, Xiao Chen, Brenna O'Masta, et. al. "First Interim Evaluation of California's Health Homes Program (HHP)." *UCLA Center for Health Policy Research*. Sept. 2020.

Regardless of whether DHCS incorporates a benefit for beneficiaries experiencing homelessness, we recommend the following changes to ECM and ILOS (explained in further detail below):

- Clarifying the ECM benefit as a benefit that does not end when a beneficiary's condition improves, but increases or decreases in intensity, according to the beneficiary's recovery.
- Eliminating administrative burdens the federal government does not require, such as billing or reporting encounters in 15-minute increments.
- Changing eligibility to focus on beneficiaries experiencing homelessness, rather than risk of homelessness, and beneficiaries who previously experienced homelessness but are now residing in supportive housing.
- Requiring plans to contract with counties or providers that subcontract with homeless continuums of care (CoCs) and community-based organizations with demonstrated success in housing beneficiaries experiencing homelessness through housing support services. The Health Homes Program demonstrated the challenges of providing services through traditional providers who may have expertise in offering medical treatment to people experiencing homelessness, but do not have expertise in successfully providing housing support services.
- Recommending staffing ratios of 20 beneficiaries per staff person, on average, for those beneficiaries experiencing chronic homelessness or beneficiaries experiencing homelessness with co- or tri-morbidities, or providing other means of ensuring beneficiaries are receiving the intensity of services they need to get and stay healthy.
- Allowing for peer-provided services, as identified in the CMS State Health Official Letter, even if that peer has a history of arrest or conviction (given the link between homelessness and past incarceration).
- Providing an "outreach rate" for the first three months of service provision, to offer incentives for providers to find and engage people often distrustful of the health care system.
- Requiring managed care plans and providers serving beneficiaries experiencing homelessness establish a homeless coordinator to foster partnership with homeless continuums of care, which are best equipped to refer members to housing, similar to a standard New Hampshire enacted in their plan contracts.[11]

Clarifying Language Around ECM as a Flexible Benefit

The populations eligible for ECM have, by definition, complex conditions and long-term needs. The provider standards include language that would transfer beneficiaries off of ECM services as soon as an assessment indicates a beneficiary can "graduate" to less intensive services. Yet, recovery is not a straight line, but a circle; beneficiaries with chronic behavioral health or medical conditions cycle between recovery and crisis or decompensating health. We recommend framing the ECM benefit as not a benefit that people transition off of or onto, but a benefit that is flexible enough for beneficiaries to have seamless increases and decreases of intensity of services, with regular assessments of their needs. Some beneficiaries may eventually no longer need ECM, but ECM should be framed as a long-term benefit that offers whatever level of intensity beneficiaries require. As an example, the Los Angeles County Department of Health Services' Housing for Health program offers high and low acuity models, with easy movement between these models to adjust to the participant's needs at any given time.

Better Defining Eligibility for Beneficiaries Experiencing Homelessness

Any benefit intended to offer services to people experiencing homelessness should focus eligibility on—

[11]New Hampshire Medicaid Managed Care Services Contract, Section 4.11.5.7.2. Feb. 2019.

- Beneficiaries experiencing homelessness, as defined by HUD,
- Beneficiaries being discharged from an institutional setting, who were experiencing homelessness upon institutional admission and therefore "at risk" of being discharged into homelessness, and
- Beneficiaries who were formerly homeless and are now residing in supportive housing.

"At risk of homelessness" is difficult to define. Research indicates even programs singularly focused on serving people experiencing homelessness have difficulties successfully identifying people truly at risk.[12] Managed care plans have varying definitions of "at risk" in the Health Homes Program (or do not define at all), which often leaves providers to define "at risk" in a haphazard and inconsistent way. A provider can find any beneficiary experiencing poverty, struggling to pay rent, as at risk, even though over 1.5 million Californians fit this description. Further, experience with national homeless programs shows homeless programs targeting "at risk" populations tend to prioritize or serve more frequently people who are housed over people experiencing homelessness, because people who are housed are easier to locate and serve,[13] even though data shows people experiencing literal homelessness drive high health care costs, and are able to reduce their Medicaid expenditures once housed. Finally, people experiencing homelessness have very different needs than households at risk of homelessness. For these reasons, and particularly because the state's proposed investment in CalAIM is limited, we propose ensuring people with the greatest vulnerabilities get served by limiting eligibility to people experiencing homelessness. Alternatively, we recommend defining "at risk" as those who are residing in an institutional setting, or being discharged from that setting, and who were homeless when admitted.

Eligibility for ECM and ILOS housing services is at the same time too narrow because it does not allow for continuous eligibility for beneficiaries once they are no longer homeless. Even though ECM and ILOS tenancy support services most logically would be offered to beneficiaries recently housed, they are currently not eligible for services under the definitions included in the requirements documents. People in recovery from chronic conditions, including homelessness, require ongoing services. Services intended to end after a brief period once someone is no longer homeless will result in returns to homelessness and potentially other dire consequences. For these reasons, we recommend allowing residents of supportive housing to continue to receive these services, or to include language that allows beneficiaries who get housed to remain eligible for services until the beneficiary's health conditions fully stabilize, at least two years after move-in.

Plans Should Contract with Providers Offering Housing Support Services, Including Non-Medicaid Providers

The State Health Officer letter acknowledged that non-traditional providers that do not have existing Medicaid contracts, but specialize in serving people experiencing homelessness, may achieve better outcomes than traditional Medicaid providers.[14] Indeed, many Health Homes Program providers struggled to offer housing navigation and tenancy support services to people experiencing homelessness, or even find these beneficiaries, despite their deep expertise in treating this population in most cases. To achieve

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[12] *See, for example,* Till Von Wachter, Marianne Bertrand, Harold Pollack, Janey Rountree. "Predicting & Preventing Homelessness in Los Angeles." California Policy Lab. Sept. 2019.

[13] A U.S. Department of Housing & Urban Development program designed to provide services and housing subsidies to people at risk of and experiencing homelessness resulted in over 70% of the funds being used to serve the "at risk" population. For this reason, HUD modified the program to remove the availability of prevention services and subsidies to those at risk, and limited the program to people experiencing homelessness. Office of Special Needs Assistance Programs, Office of Community Planning & Development, HUD. *Homelessness Prevention & Rapid Re-Housing Program (HPRP): Year 3 & Final Program Summary.* Jun. 2016.

[14] State Health Official Letter #21-001.

success, community-based organizations that are "homeless service" and "housing providers," Healthcare for the Homeless providers, and health centers with strong, longstanding success in outreaching to and serving people experiencing homelessness, are able to achieve better outcomes than traditional Medicaid providers who hire staff to fill a housing navigator role for the purpose of ECM or ILOS. A provider should not only have experience serving beneficiaries experiencing homelessness, but should also have *experience providing housing support services and achieving successful outcomes in getting people and keeping people stably housed*. In the alternative, plans should contract with counties or providers who will subcontract with community-based organizations that successfully provide housing support services.

The recent UCLA interim evaluation of the Health Homes Program showed over 84% of Community-Based Care Management Entities primarily offered medical models of care coordination, hiring in-house staff to provide housing navigation. As a result, only an estimated 3.5% of HHP beneficiaries among Group 1 and 2 plans ever experienced homelessness and only 38% of *this* small percentage received any housing support services.[15] The managed care plan with the highest percentage of enrolling HHP beneficiaries experiencing homelessness was the Inland Empire Health Plan, which had a direct contractual relationship with homeless service providers, Brilliant Corners and Step Up on Second, to identify beneficiaries experiencing homelessness and provide housing navigation and tenancy support services.[16]

Administrative Requirements

The administrative requirements articulated in the provider standards will dissuade many homeless service and housing providers from enrolling as ECM or ILOS providers. Community-based organizations are typically not equipped to dedicate more dollars on administrative requirements than on service delivery. In fact, funding for these providers often "starves" these programs of administrative resources. For managed care plans to develop and grow their capacity in serving this population, we recommend the following:

- *Remove billing & reporting requirements in 15-minute increments*: Encounter reporting and billing in 15-minute increments impedes a person-centered model. These reporting requirements not only interfere with the relationship between clients and providers, in having to document every 15 minutes, they are highly burdensome and will prevent many providers from accessing ILOS or ECM. This billing and reporting requirement also serves little purpose. A 15-minute reporting requirement in the Health Homes Program has failed to result in frequent in-person units of service (the average number of units of service was less than 2 per month).[17] We recommend offering a supplemental per person, per month rate instead, and requiring monthly reporting on the types of services and the total number of contacts with beneficiaries. Simpler reporting and billing will allow managed care plans to foster capacity.
- *Remove requirements based on a medical model of care:* As ECM and ILOS are intended to offer services to beneficiaries with social determinants of health and medical models have typically not served these beneficiaries well, we recommend removing requirements that are hold-overs from medical models:
    - *Remove requirement for providers to create and staff a telephone line available 24 hours per day, 7 days a week*: We recommend instead requiring providers to offer beneficiaries the ability to contact their case manager or care coordinator directly. For providers serving beneficiaries experiencing homelessness, staffing a telephone line 24/7 would add significant administrative cost and little benefit for beneficiaries who are far more likely to reach out to a case manager they know than a staffed phone line.

[15]Nadereh Pourat, Xiao Chen, Brenna O'Masta, et. al. "First Interim Evaluation of California's Health Homes Program (HHP)." *UCLA Center for Health Policy Research*. Sept. 2020.
[16]First Interim Evaluation of California's Health Homes Program (HHP).
[17] *Ibid*.

- *Remove distinctions in payment between traditional Medicaid providers and other providers:* We recommend requiring managed care plans to provide payment within 30 days for providers that are not individual or group practices or health facilities, the same as payment deadlines for traditional medical providers, as providers without large medical practices may have less capacity, not greater, to wait 90 days for payment.

- *Modify requirements for outreaching to beneficiaries:* The ILOS Provider Standards require providers to outreach to members within 24 hours of assignment, yet acknowledge that beneficiaries experiencing homelessness may be difficult to find. The 24-hour outreach requirement will spur many providers to send a letter to "check the box" of beginning outreach, which will fail to engage beneficiaries experiencing homelessness. Instead, we recommend clarifying that providers must begin in-person outreach *efforts* within 24 hours or attempting to locate "difficult to reach" beneficiaries.
- *Remove requirements for providers to enroll as Medicaid providers:* The Provider Standard Terms and Conditions requires providers to become enrolled Medicaid providers where an enrollment pathway exists, or to undergo managed care plan enrollment and background checks. We instead recommend following federal law that allows for contracting with non-traditional providers in serving beneficiaries experiencing homelessness.[18]

Staffing Ratios & In-Person Services

While DHCS clearly intends to fund primarily in-person services through ECM and ILOS, providers were more than two times more likely to engage beneficiaries telephonically than in-person in the Health Homes Program.[19] For these reasons, we recommend identifying ways to connect with beneficiaries suitable for the beneficiaries' unique needs, and promoting staffing ratios that work for the beneficiaries being served. For beneficiaries experiencing homelessness and co- or tri-morbidities, or chronic homelessness, we recommend staffing ratios of 1:20 to ensure the intensive, in-person nature of the services DHCS is expecting under ECM and ILOS, and clarifying the specific circumstances in which services may be offered telephonically. The standard DHCS identifies of "sufficient experience and expertise" is broad and undefined, and therefore is not meaningful for managed care plans or providers.

Outreach Services

Managed care plans typically struggle to identify members experiencing homelessness and traditional providers often struggle to enroll beneficiaries experiencing homelessness. One reason for the latter is often because providers do not begin receiving payment unless and until the beneficiary consents to participate in the program. Beneficiaries experiencing homelessness are less likely to walk into a community health center or primary care physician's office seeking care, and so are harder to enroll, often requiring providers to find beneficiaries, build trusting relationships, and engage the beneficiaries to want to participate in the program, sometimes taking months of in-person outreach and engagement efforts.

For these reasons, we appreciate that the CalAIM requirements allow managed care plans to fund past initiation of outreach services once beneficiaries enroll in ECM, and encourage managed care plans to offer incentive payments for hard-to-find beneficiaries. However, these remedies do require providers to wait the significant time it could take to enroll beneficiaries experiencing homelessness before receiving payment. For this reason, we recommend paying plans and providers for a three-month outreach period for beneficiaries eligible, prior to a beneficiary's enrollment, following a New York Health Homes Program

[18]State Health Officer Letter #21-001.
[19]Interim Evaluation of California's Health Homes Program (HHP).

model. This three-month period would allow providers to receive payment while finding and engaging beneficiaries experiencing homelessness, and would allow providers to get paid for these services when they are providing them, even if the managed care plan does not offer incentive payments. DHCS could also allow managed care plans to pay incentives for providers who enroll a specific percentage of beneficiaries experiencing homelessness (i.e., 25% or higher beneficiaries experiencing homelessness), and incentives for moving those beneficiaries into housing.[20]

Further, we recommend clarifying when a provider may conduct outreach through letters, e-mails, texts, and other methods that are not in-person. Currently, the Model of Care Template suggests that a provider must conduct in-person outreach to eligible beneficiaries, but switch to other methods of outreach, "if in-person outreach is unsuccessful." Because the requirements documents do not define "in-person attempts" or "unsuccessful attempts," we recommend further guidance that requires at least three attempts from staff, such as peers with lived expertise of homelessness, who have outreach experience in successfully identifying and engaging beneficiaries experiencing homelessness.

Challenges in ILOS

Under the Model of Care Template, if plans offer any ILOS category of services in a single county, the plan has to offer those services to all who are eligible. While we agree with this approach in principle, we anticipate it will result in plans narrowing eligibility significantly to avoid serving more members than their capacity allows. We recommend instead allowing plans to explore broader eligibility, without requiring them to offer services to all who are eligible, and then expand their capacity to serve all eligible beneficiaries over time.

Additionally, under the provisions of the contract template, managed care plans may decide every 12 months whether to discontinue ILOS by "seamlessly transitioning the Member into other Medically Necessary Services." Yet, by their very nature, these services are not covered benefits and are not typically offered through other Medi-Cal programs. Allowing managed care plans to remove ILOS services at 12-month intervals could result in dissuading any number of homeless service providers from contracting with managed care plans, as the level of uncertainty from one year to the next could result in unstable funding. Considering beneficiaries will be relying heavily on services to get and stay stably housed, eliminating funding for these services will likely result in beneficiaries getting cut off from needed services, which could result, in turn, in returns to homelessness and deterioration of behavioral health and medical conditions (potentially with devastating impact). We recommend requiring managed care plans to commit to ILOS services, once offered, to continue to fund housing support services through their community benefits, even though not enrolling additional members into ILOS. While we understand ILOS is optional for plans, once a managed care plans commits to funding services under ILOS, a decision to terminate funding for services has real life consequences.

Identifying Beneficiaries Experiencing Homelessness

The Model of Care Template requires managed care plans to describe a process for identifying members who can benefit from ECM through processes for data analyses and provider and external source referral. One of the challenges UCLA Health Homes Program evaluators identified was managed care plan difficulties in identifying their members or members on the targeted engagement list experiencing homelessness. As a result, only 2-4.4% of all HHP beneficiaries were homeless, well below estimates of

[20] 42 CFR Section 438.6.

DHCS actuaries and CSH staff estimates.[21] While we agree with data sharing requirements, we further recommend requiring managed care plans and providers partner with local homeless continuums of care and community-based homeless service providers operating coordinated entry systems.

Coordinated entry systems assess the needs of people experiencing homelessness within their geographic reach and refer people to housing and services available in the community. Partnerships with homeless continuums of care and coordinated entry systems could allow designated staff within managed care plans to receive consents and data on beneficiaries experiencing homelessness.

Continuity of Care for WPC and HHP Beneficiaries Experiencing Homelessness

We generally agree with the provisions in the requirements documents around transitioning Whole Person Care and Health Homes Program beneficiaries and providers into ECM and ILOS. However, because ECM does not fund housing support services, many beneficiaries currently receiving services through Whole Person Care or the Health Homes Program will be cut off of these services. Though ECM offers "referrals" to housing, in most counties, referral to a homeless services provider will not result in meaningful connection to housing. Few resources fund housing support services, particularly for the 70% of beneficiaries without a diagnosed serious mental illness who are not eligible for Mental Health Services Act services. As noted above, loss of these services could have devastating consequences for beneficiaries currently receiving them. We therefore recommend DHCS identify a continuity of care plan to allow managed care plans to transition off of the Health Homes Program over a 12-month period, to fund housing support services for beneficiaries receiving Health Homes Program services. We further recommend DHCS identify a path for Whole Person Care beneficiaries to avoid being cut off of these services.

Coding Guidance

We appreciate the guidance allowing ILOS payment on a per diem basis for housing navigation, but recommend instead payment on a per member, per month basis. We strongly recommend allowing ECM payment and ILOS payment for tenancy sustaining services on a similar per member, per month basis as well, rather than through a process requiring billing in 15-minute encounters. Fifteen-minute increment billing is not feasible for most social service providers who are not currently Medicaid providers, and consumes significant administrative time and expense. It stifles flexibility, adds burdens, wastes money, and limits capacity of providers. A per member, per month basis allows for flexibility, and most closely aligns with the way homeless services are typically funded.

Additional Steps to Integrate Medical, Behavioral Health, and Social Determinants of Health

To further the goals of CalAIM to provide "whole person" oriented care that takes into consideration social determinants of health, DHCS could take further steps as part of the CalAIM reform to address the needs of beneficiaries experiencing homelessness. The State Health Officer letter offered several recommendations to states California could adopt, including the following:

- Develop a relationship with state and local housing agencies to help beneficiaries access housing, such as partnering with the Department of Housing and Community Development to tie services DHCS is funding to eligibility for programs like Housing for a Healthy California and the Multifamily Housing Program;

[21] HHP evaluation report: Nadereh Pourat, Xiao Chen, Brenna O'Masta, et. al. "First Interim Evaluation of California's Health Homes Program (HHP)." *UCLA Center for Health Policy Research*. Sept. 2020.

- Provide technical assistance to managed care plans in coordinating with local housing locator and tracking systems, including homeless continuums of care and local coordinated entry systems that refer residents experiencing homelessness to housing and services;
- Create presumptive eligibility for people experiencing homelessness, to allow community-based organizations to screen for eligibility and immediately enroll beneficiaries experiencing homelessness; and
- Draft multi-benefit applications to allow for streamlined opportunity to connect beneficiary to multiple state benefits, thereby enhancing access to these benefits, as an alternative to the Medicaid application.

General Concerns That the Requirements Document and Updated Proposal Do Not Address

We continue to have concerns with several CalAIM proposals:

- ECM compels plans to offer additional services without the funding or timeline needed to stand up a new program and have it function effectively. In fact, CalAIM shrinks funding available for ECM and ILOS, while expanding eligibility well beyond the Whole Person Care and Health Homes Programs.
- Providing the housing-based services listed above (housing navigation, transition, and sustaining services) through ILOS will significantly erode availability of services. These services will likely be less accessible to beneficiaries experiencing homelessness than services currently funded. These three categories of services, where offered, would be available to fewer beneficiaries, in a less standardized manner (with different models potentially in the same county).
- Funding these services through ILOS would not satisfy the stated goals of standardization, statewide implementation, and increased plan participation, and would severely limit access to these critical supports for beneficiaries experiencing homelessness, particularly as offered in separate categories of services.

The undersigned organizations continue to call for Medi-Cal funding for services that would meet the unique needs of beneficiaries experiencing homelessness. We look forward to working with the Administration to heed the example of other states, the guidance of CMS, and the recommendations of experts to fulfill the promise and intent of CalAIM for this population. We can ensure systems discharging people into homelessness become instead responsive to homelessness, if Medi-Cal can meet the unique needs of this fragile population. Thank you for considering our recommendations.

Sincerely,

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Many states recognize that services that help people access housing and maintain housing stability can improve both individual health outcomes and the health of communities, while reducing Medicaid spending. These services can also be a key strategy in improving health equity in a community, as people of color are disproportionately represented among people experiencing homelessness and individuals with disabilities who are housed in inappropriate institutions. For most communities however, the lack of sustainable services funding is a primary barrier to increasing the supply of housing and for helping people access housing, housing subsidies, and housing stability. States have recognized that historical funding for supportive housing services - short-term government and philanthropic grants – is not sustainable and have looked for financing solutions to help meet the scale of need. Health care system financing offers the promise of bringing supportive housing to scale for many communities.

The National Association of Medicaid Directors (NAMD), in a report envisioning the future of Medicaid, encouraged states to better serve populations experiencing homelessness and housing instability, by expanding "supportive housing services."[22] Based upon the 2015 CMS Informational Bulletin, a number of states were approved for 1115 research and demonstration waivers to cover housing support services including Massachusetts, Maryland, Washington,[23] Florida, Hawaii, and Virginia. Minnesota was the first state in the nation to have an approved 1915(i) SPA for what they are calling "Housing Stabilization Services." North Dakota was approved for a similar 1915(i) SPA and Connecticut and New Hampshire are in negotiations with CMS regarding their housing services related SPAs. Other states are taking a broader "Social Determinants of Health"[24] approach that includes housing related assistance as well as working to address other social needs of their residents, including food, transportation, interpersonal violence and addressing the digital divide. Oregon and North Carolina are two examples.

SUMMARY OF STATE ACTIVITY

State/City	Program Model	Medicaid Mechanism	Target Population	Status
Connecticut	Tenancy Support Services for High Cost/ High Need complex care population The Connecticut Housing Engagement and Support Services (CHESS) Initiative	1915(i) State Plan Amendment or SPA.	Age 18 and over, HUD defined homelessness, particular diagnoses and a risk score as defined by the Healthcare Effectiveness Data and Information Set (HEDIS) Plan All-Cause Readmissions measure, and that the individual is experiencing more significant inpatient services	SPA Submitted to CMS. State submission to CMS State Initiative website

[22] https://medicaiddirectors.org/wp-content/uploads/2021/02/NAMD_MedicaidForwardReport_FEB2021.pdf
[23] http://www.cshp.rutgers.edu/publications/medicaid-demonstration-waivers-with-housing-supports-an-interim-assessment
[24] https://www.cdc.gov/socialdeterminants/index.htm

			than would be predicted based on the individual's risk score.	
Florida	Pilot Program in 5 Central Florida Counties: Brevard, Pasco, Pinellas, Osceola and Seminole. Services include Pre-Tenancy, Tenancy Sustaining Services and Mobile Crisis Management and Peer Support.	1115 Waiver Amendment	21 and Older with significant Behavioral Health needs and Homeless or at risk of homelessness. Noted as a pilot program, Program cap is noted as "42,500 member months".	Operating. Waiver Amendment approved 3/26/2019. State and MCOs are developing the implementation plan. CMS Approved Waiver Health Plans and Community Mental Health Centers are the lead. The Health Plans in these 5 counties include Humana, Staywell, Simply Healthcare and Sunshine Health State Snapshot of MCOs
Hawaii	1115 Waiver amendment focused on services to increase supportive housing capacity for the state.	1115 Waiver	Behavioral Health, physical illness or a substance use diagnosis and chronically homeless. Persons experiencing homelessness. Persons living in institutions, who cannot be discharged due to a lack of appropriate housing plan for discharge. Persons identified by Queen's Hospital Homeless Project. Had been state only funded and goal is to shift services to Medicaid.	Operating Waiver approved by CMS 10/31/2018. After health plan assignments, people eligible for the service, will be assigned a service coordinator from the health plan that will work with them to obtain services and housing. Benefit to be managed by the state's Managed Care delivery system which at the start of 2020 includes Aloha Care, HMSA Ohana Health Plan and United Healthcare.

			Living in Public Housing and at Risk of eviction AND has a qualifying condition/ diagnosis.	
Maryland	Use Medicaid for Tenancy Support Services	1115 Waiver	Housing Status criteria: Persons who are either experiencing homelessness or transitioning to the community from an institution or at high risk of institutional placement. In a Nursing Home for at least 60 days. Health Status Criteria- 4 or more hospital visits in a year (can be ED or Inpatient) OR two or more chronic conditions.	Operating. County driven, as counties are required to put up what has historically been 'state match' funding as well as the aligned housing resources. State Web site for ACIS project
Massachusetts	Flexible Services to expand housing and nutritional supports vulnerable members identified by their Accountable Care Organizations or ACOs.	1115 Waivers set the structure as ACOs. ACOs have an allocation for "Flexible Services" and can include housing assistance.	TBD by each ACO and their community partners. MA ACO and MCO listing	Operating. Beginning in January, 2020 ACOs or their Community Based Organization partners could deliver housing support services to targeted members. The state calls these Flexible Services **DSRIP Year 3 Guidance**
	Medicaid funds used for tenancy support services, billed monthly on a per diem rate. Project is called CSPECH or	1115 waiver	Members who are chronically homeless or high utilizers of homeless and healthcare services. Initial cap of 50 was expanded to 500-800 individuals through 2022.	Operating. CSH Project Profile Outcomes report Outcomes Report

	Community Support Program for people Experiencing Chronic Homelessness. Pays supportive housing providers to deliver housing based case management ($17 per day, per person).Provider can bill up to 60 days prior to lease up for services.		Limited to Medicaid recipients who are members of an MCO or a Primary Care Clinician Plan.	
Michigan	Community Support Services including Housing Assistance, Skill Building Assistance and Supportive/ Integrated Employment	1115 Behavioral Health Transformation waiver through 2022. 1915(i) State Plan Amendment after 2022.	Persons with Serious Mental Illness, Serious Emotional Disturbance and/or Intellectual/ Developmental Disabilities.	Services are a component of the state's Behavioral Health Transformation Plan which was approved under an 1115 waiver. The state is focusing on the development of the PrePaid Inpatient Health Plans or PHIPs that manage a network of community behavioral health providers. CMS approved 1915(i) SPA
Minnesota	Housing Stabilization Services to support transition to the community, increase long-term stability in the community & avoid future periods of homelessness or institutionalization.	1915(i) State Plan Amendment	People with disabilities, including mental illness, who are homeless or at risk of becoming homeless, are living in institutions or other segregated settings, or are at risk of living in those settings and adults who are 65 years or older who are homeless or at risk of becoming homeless.	Operating Housing Stabilization Services Services began July 20, 2020. MN is the first state approved to use a 1915(i) State Plan Amendment or SPA.
Nevada	Housing Support Services	1915(i) State Plan Amendment	TBD	Planning NV has legislative approval to develop a 1915(i) SPA. State is also developing Standards of Care and materials to support provider capacity building.

New Hampshire	Housing Support Services	1915(i) State Plan Amendment	TBD- State aligning with housing resources to expand Supportive Housing Capacity	Submitted to CMS. State includes a variety of housing related requirements in MCO contracts including housing Coordinator Role within the MCO, and MCO's risk scoring and stratification is required to take into account homelessness and housing instability.
North Dakota	Housing Support Services to 3 new affordable housing projects being developed by Housing Authorities	1915(i) State Plan Amendment	People with behavioral health challenges who are experiencing homelessness and housing instability.	Approved by CMS 1915(i) State Plan Amendment
Pennsylvania	Tenancy Support Services for IDD/DD population	1915(i) State Plan Amendment	Those already eligible for IDD waivers. Process remains the same as prior to the waiver.	Operating Tenancy support services are now added to the menu of services available for persons eligible for the IDD waiver.
Rhode Island	Home Stabilization Services	1115 Medicaid Waiver	Persons with Behavioral Health or Intellectual Disabilities. Those institutionalized or at risk of institutionalization	Operating Waiver approval at CMS approved waiver State Project Website State has created Home Stabilization Standards to guide the program
Utah	Housing Support Services for certain Medicaid enrollees	Not clear at this time	TBD	Planning Legislature approved state Medicaid office to develop tenancy support services. https://s3.amazonaws.com/fn-document-service/file-by-sha384/9d641ed93b4ceb13080fb9f190be2a09d2fb6c6db57ff4588108060ccbab97e745955fe9b4717c0dc82b24526ff24baf

VA	Services in Supportive Housing	1115 Waiver	State to develop high needs target criteria that can include health based needs criteria such as Behavioral Health, Substance Use Disorder, Complex Medical Needs AND Risk Factors including Chronic Homelessness, institutionalization, criminal justice system involvement, high rate of ED use and/or significant housing instability.	Planning CMS approved Waiver approved as of 7/9/20. Next state steps is expected to take at least a year.
Washington State	Foundational Community Supports for supportive housing and supportive employment services.	1115 Waiver	People experiencing chronic homelessness, individuals with frequent or lengthy adult residential care stays, individuals with frequent turnover of in-home caregivers and those at highest risk for expensive care and negative outcomes	Operating, Waiver approved and implementing as of 1/1/2018. State Program website Amerigroup as third party administrator **Daily rate of $112 with a benefit limitation of 30 days over a 180-day period.**