CalAIM's Housing-Related Services:

Enhanced Care Management & Community Supports

June 2024

Homebase

- Subject matter expertise in homelessness and cross-system coordination
- Work at the federal, state, and local levels with an emphasis in California
- Assist communities and agencies to establish systems and programs needed to help people experiencing homelessness achieve housing stability and improve health and wellness

Saadiqah Islam, *Policy Analyst*

Gillian Morshedi, *Directing Attorney*

Alissa Weiss, *Directing Analyst*

Innovative Thinking & Solutions

Transformational | Strategic | Practical

Context and Purpose

- Housing is a social determinant of health and health care access is critical for maintaining housing
- People with complex care needs often touch the public health, health care, and homeless systems of care; collaboration is crucial
- New Medi-Cal initiatives have created opportunities to support cross-system partnerships and bring resources to people experiencing homelessness.
- **CDPH is working to strengthen the connection between Local Health Jurisdictions and homeless systems of care**
- Homebase research (surveys, interviews, listening sessions) revealed amazing LHJ efforts and a desire to learn more
- Effective collaboration and resource use requires education

Agenda

- ✓ Overview of Critical Health System Resources
  - Enhanced Care Management (ECM)
  - Housing-related Community Supports (CS)
- ✓ Maximizing ECM and CS: Guidance for Connecting Clients to these Resources
- ✓ Q&A and Discussion

Overview of New Health Resources

California Advancing & Innovating Medi-Cal (CalAIM)

- Effective January 2022 through 1115 Medicaid Waiver
- New Medi-Cal initiative to improve the health of Californians, especially those with the most complex needs.
- People experiencing homelessness who have physical/behavioral health issues = population of focus.

CalAIM Housing-Related Medi-Cal Services

Many new programs under CalAIM - 2 offer housing-related services:

- **Enhanced Care Management (ECM) -** All MCPs must provide ECM to their eligible members
- **Community Supports (CS) -** MCPs opted in to provide specific community supports to their eligible members (most are starting with some; can add more over time)

Key goal: allow members to obtain care in the least restrictive setting possible and to keep people in the community

Enhanced Care Management (ECM)

- For Medi-Cal members with **complex care** needs
  - Goal: coordinate all primary, acute, behavioral, development, oral, social needs, and long-term services and supports, including participating in care planning
- Intensive care coordination & services across multiple systems to help address both clinical and non-clinical needs
  - Intended to be interdisciplinary, high touch, person-centered and provided primarily through in-person interactions with members where they live, seek care & prefer to access services
  - ECM providers must meet members where they are in their communities, not just at the Dr.'s office (e.g., at shelters, on the street, or at home)
  - Care managers help Medi-Cal members set clear goals, ensure they receive the full array of benefits they are eligible for, and coordinate across systems
- Anyone can refer Medi-Cal members for ECM, including self-referrals

See DHCS CalAIM ECM Policy Guide for more details

ECM Populations of Focus

CalAIM Care Management Continuum

Enhanced Care Management (ECM) is for the **highest-need members** and provides intensive coordination of health and health-related services.

Complex Care Management (CCM) is for members at **higher- and medium-rising risk** and provides ongoing chronic care coordination, interventions for temporary needs, and disease-specific management interventions.

Basic Population Health Management (BPHM). BPHM is the array of programs and services for **all** MCP members, including care coordination and comprehensive wellness and prevention programs, all of which require a strong connection to primary care.

Transitional Care Services are also available for all Medi-Cal Managed Care Plan (MCP) members transferring from one setting or level of care to another.

ECM Core Service Components

ECM activities should be integrated w/ other care coordination → In most cases ECM Provider should assume primary responsibility of coordination of members' needs, including collaborating with other coordinators

- Outreach and engagement
- Comprehensive Assessment and Care Management Plan
- Enhanced Coordination of Care
- Health Promotion
- Transitional Care Services
- Member and Family Supports
- Community and Social Support Services Coordination and Referrals

Community Supports (CS)

- For Medi-Cal members with **complex health needs** and **unmet social needs**
- MCPs can provide as many of the 14 pre-identified services as possible:
  - Housing transition navigation services
  - Housing tenancy and sustaining services
  - Recuperative care (medical respite)
  - Caregiver respite services
  - Community transition services/nursing facility transition to a home
  - Environmental accessibility adaptations (home modifications)
  - Sobering centers
  - Housing deposits
  - Shorter-term post hospitalization housing
  - Day habitation programs
  - Personal care and homemaker services
  - Nursing facility transition/diversion to assisted living facilities
  - Medically supportive food/meals/medically tailored meals
  - Asthma remediation

For more details about each Community Support, see DHCS Community Supports Policy Guide

Housing Transition/Navigation Services

Intended to help eligible Medi-Cal members **navigate the process of searching for and obtaining housing.**

- Specific services offered should be based on each person's assessment and documented in an individualized housing support plan.
- Services may need to be coordinated with other entities to ensure that members have access to the comprehensive supports required to access and retain stable housing and CS providers may need to coordinate closely with the local Coordinated Entry System.

Eligibility - People who:

- are prioritized for PSH or rental subsidy through local CES
- meet HUD definition of homeless AND who receive ECM or have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or who may require residential services as a result of a substance use disorder.

Restrictions/Limitations:

- Duration: While specific Housing Transition/Navigation services must be identified as reasonable and necessary based on the individual's housing support plan, **the duration of services can go on as long as necessary**.

Housing Transition/Navigation Services: Covered Services

- Conduct screening & housing assessments to id member's preferences and barriers that prevent accessing & maintaining stable housing.
- Develop an individualized housing support plan that addresses barriers, develops goals & approaches to each housing issue, & identifies additional providers/services needed.
- Search for & share housing options with the member.
- Assist in obtaining housing (incl. completing housing applications and accessing required documentation (e.g., Social Security card, birth certificate, prior rental history).
- Assist with requests for reasonable accommodation, incl.: identify, coordinate, secure and fund environmental modifications for necessary accessibility accommodations.
- Assist with benefits advocacy + Identify & secure resources for members to access subsidized rent programs (e.g., HCVs).
- Identify and secure resources to cover expenses like security deposits, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses.
- Educate and engage the landlord; communicate with the landlord and advocate on behalf of the member
- Ensure the living environment is safe and move-in ready + Help arrange and support the move.
- Establish contacts and procedures to retain housing.

For more details about each Community Support, see DHCS Community Supports Policy Guide

Housing Tenancy & Sustaining Services (TSS)

Intended to help eligible Medi-Cal members **maintain safe and stable tenancy once they have housing.**

- TSS must be identified as reasonable and necessary in the Medi-Cal member's individualized housing support plan. They only are available when the member is unable to successfully maintain longer-term housing without such assistance

Eligibility - People who:

- received Housing Transition/Navigation Services
- meet HUD definition of homeless AND who receive ECM or have one or more serious chronic conditions and/or serious mental illness and/or are at risk of institutionalization or who may require residential services as a result of a substance use disorder.

Restrictions/Limitations:

- Duration: The TSS are available from the start of services until the individual's housing support plan determines they are no longer needed. The length of services can be **as long as necessary.**
- Frequency: TSS are only available **once in an individual's lifetime.** The MCP can approve one additional time with documentation as to what conditions have changed to demonstrate why providing TSS would be more successful on the second attempt.

Housing Tenancy and Sustaining Services: Covered Services

- Early id of and intervention around behaviors that may jeopardize housing (e.g., late rental payment, hoarding, substance use).
- Educate & train on the role, rights, and responsibilities of the tenant and landlord. Help Medi-Cal members develop and maintain key relationships with landlords/property managers.
- Coordinate with a landlord and case manager to address identified issues that could impact housing stability and assist to resolve disputes with landlords and/or neighbors to reduce the risk of eviction or other adverse actions.
- Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
- Assist with benefits advocacy
- Coordinate to review, update and modify housing support and crisis plan on a regular basis.
- Ongoing assistance with lease compliance, including ongoing support with activities related to household management.
- Health and safety visits, including unit habitability inspections.
- Other prevention and early intervention services identified in the crisis plan that are activated when housing is jeopardized
- Assistance with independent living, life skills, and training on budgets, including financial literacy and connection to community resources.

For more details about each Community Support, see DHCS Community Supports Policy Guide

Asthma Remediation

Physical modifications to a home environment that are necessary to **ensure the health, welfare, and safety** of the individual or enable the individual to function in the home and **without which acute asthma episodes** could result in the need for **emergency services and hospitalizations**

Eligibility - People with:

- Poorly controlled asthma (as determined by ED visit or hospitalization or two sick or urgent care visits in the past 12 months or score of 19 or lower on Asthma Control Test)
- For whom a licensed health care provider has documented that the service will likely avoid asthma-related hospitalizations, emergency department visits, or other high-cost services

Restrictions/Limitations:

- If another State Plan service like Durable Medical Equipment is available and would accomplish same goals
- Total lifetime max of $7,500 (unless member's condition has changed significantly)
- Asthma remediations must be conducted in accordable with applicable State law/local building codes, are limited to those of direct medical benefit to the member

Asthma Remediation: Covered Services

Services available in a home that is owned, rented, leased, or occupied by a member or their caregiver.

Includes providing info to members about actions to take around the home to mitigate environmental exposures that could trigger asthma symptoms and remediations designed to avoid asthma-related hospitalizations.

- Allergen-impermeable mattress and pillow dustcovers
- High-efficiency particulate air (HEPA) filtered vacuums
- Integrated Pest Management (IPM) services
- De-humidifiers and other moisture-controlling interventions
- Air filters
- Minor mold removal and remediation services
- Ventilation improvements
- Asthma-friendly cleaning products and supplies
- Other interventions identified to be medically appropriate and cost effective

CalAIM as a Critical Funding Source

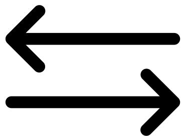
- Opportunity to increase overall funding/staff capacity (with braiding)
- Medi-Cal is an entitlement program
  - + available regardless of immigration status
- Expansive services covered (though caps may apply)
- Funded by the federal government/state

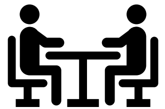
Maximizing ECM and CS

LHJs' Role in advancing ECM and CS

In collaboration with your CoC…

Identify


Refer


Provide(r)

Educate

Identify

- Access to health care through Medi-Cal is vital – and the first step in receiving ECM and CS services and support
- **Identify people** eligible for Medi-Cal, ECM, and CS services and support with Medi-Cal enrollment where possible:
  - Ask about Medi-Cal status during client interactions; share Medi-Cal enrollment steps with clients
  - Encourage county informational/enrollment fairs to help people exp homelessness apply for Medi-Cal, ECM and CS

Refer

- Many LHJs have direct relationships with clients and can work with their CoC and MCP to refer clients for ECM/CS services
  - Learn which Community Supports your local MCP offers
  - Know the referral forms MCPs use and the processes they require
  - Work with your MCP and CoC to develop a streamlined referral protocol
  - Work with your CoC and MCP to strengthen referral follow up process, including a consistent way for ECM and CS providers to connect with partners who already engage with members.

Provide(r)

- Many LHJs run programs that overlap with the key services provided through ECM and CS.
- Becoming an ECM and/or CS provider is a unique way to leverage Medi-Cal funding and conserve public health dollars
- Consider becoming an ECM/CS provider:
  - Review overlap between key ECM/CS activities and existing LHJ programming
  - Work with your MCP to learn about what it takes to become a contracted ECM and/or CS provider

Educate

- LHJs work closely with people experiencing homelessness and can play a role in ensuring that ECM and CS programs meet the unique needs of this population:
  - Help MCPs understand unique health care and social services needs of people experiencing homelessness
  - Work with MCPs to ensure people experiencing homelessness are referred to ECM and CS providers who understand homelessness

Questions?

Discussion

- **Have you explored any of the ideas we raised?**
  - Are you referring clients for ECM or any Community Supports?
  - Have you considered becoming an ECM or CS provider?
- **Which of these ideas resonated? Which did not?**
- **What did we miss?**
- **What additional resources/tools would you need to do this?**

Resources

- Homebase website: Resources for Building Health Care-Homeless Response System Partnerships
  - HHIP Implementation Toolkit for CoCs (including CalAIM's Community Supports: Housing-Related Services)
  - Materials on Understanding and Leveraging CalAIM:
    - CalAIM Basics & CalAIM's Housing-Related Services
    - The Housing & Homelessness Incentive Program (HHIP)
    - Opportunities for Homeless Systems of Care under HHIP
  - Recommendations to Improve Implementation of ECM/CS
  - Webinars on Health Care-Homeless System Collaboration
- DHCS resources
  - ECM and Community Supports page
  - Housing and Homelessness Incentive Program site: resources, informational webinar, submission materials (templates and metrics)

Thank you!

Reach us at healthcare@homebaseccc.org with any final thoughts or questions