HHIP Implementation Toolkit for CoCs

Homebase
with the support of the California Health Care Foundation

The HHIP Implementation Toolkit contains guidance and planning documents intended to support Continuums of Care (CoCs) and homeless assistance partners to engage with their local Medi-Cal managed care plans (MCPs) to efficiently and impactfully implement the Housing and Homelessness Incentive Program (HHIP).

Some documents within the Toolkit are intended to directly provide CoCs with critical information about the HHIP program and MCPs' motivations to meet HHIP metrics. Others are intended to help CoCs communicate to MCPs about their own systems, goals, strengths, and limitations. Each document can be referenced and used separately, depending on the needs of each CoC and community.

The HHIP Implementation Toolkit is meant to help facilitate communication and planning efforts between CoCs and MCPs. The Toolkit can help build or strengthen partnerships for successful HHIP implementation. It is also meant to facilitate long-term cross-system coordination and collaboration to improve housing and health outcomes for those experiencing homelessness.

The following additional resources relevant to CalAIM's Housing-Related Services, the Housing and Homelessness Incentive Program (HHIP), and cross-system collaboration between CoCs and health care system partners including MCPs are available on Homebase's Building Health Care-Homeless Response System Partnerships resource page:

Understanding and Leveraging CalAIM (A California Medi-Cal Initiative):

- CalAIM Basics
- CalAIM's Housing-Related Services
- The Housing and Homelessness Incentive Program (HHIP)
- Opportunities for Homeless Systems of Care under HHIP

Breaking Down Silos: How to Share Data to Improve the Health of People Experiencing Homelessness

How to Share Data: A Practical Guide for Health and Homeless Systems of Care

The following eight resources and tools are included:

Fundamentals of Homelessness Response for Managed Care Plans

Foundational information for CoCs to provide to MCPs about how homeless assistance works at the local level, including practical, action-oriented suggestions to help MCPs participate in their community's response to homelessness.

Understanding HHIP Performance Metrics

An explanation of how the Department of Health Care Services intends to measure whether MCPs have met the HHIP metrics required to draw down HHIP incentive award funds, including information MCPs must report for each metric for the second reporting period and how CoCs can collaborate with MCPs on that process.

Maximizing CalAIM's Enhanced Care Management (ECM) Benefit and Community Supports (CS) Services

Guidance for CoCs on how to work with their local MCPs to ensure that people experiencing homelessness who are eligible for these crucial housing-related benefits and supports are referred and connected with ECM and CS providers.

CalAIM's Community Supports: Housing-Related Services

An overview of key details about four housing-related Community Supports: Housing Transition/ Navigation Services, Housing Tenancy & Sustaining Services, Housing Deposits, and Short-Term Post Hospitalization Housing.

Bi-lateral Data Sharing Agreement Between a Continuum of Care and Managed Care Plan

A sample bi-lateral data sharing agreement (DSA) to help cross-sector partners identify the common components of a DSA between CoC agencies responsible for HMIS data and Medi-Cal MCPs.

Needed HMIS Data Elements for Partnering with Managed Care Plans

Recommendations for CoCs on additional data elements to add to their local HMIS to facilitate cross-sector data sharing that can better enable MCP partners to coordinate and collaborate.

Sample Workflow for Continuums of Care and Managed Care Plans to Conduct a Client Data Match

A sample workflow and list of data elements that CoCs and MCPs can use to match their client and member data to identify shared clients and improve cross-system care coordination.

Medi-Cal and HHIP Coverage for Street Medicine

An overview of California Department of Health Care Services' street medicine rules, to help CoCs better understand what aspects of street medicine are covered under CalAIM and relevant to HHIP metrics and to inform CoC discussions with their local MCPs to build or expand street medicine access in their communities.

HHIP Expenditure Planning – Moving Beyond the Metrics: Shifting Focus from Earning HHIP Funds to Allocating Them

Guidance and tools to help CoCs and their partner MCPs discuss and determine how best to allocate and spend earned HHIP incentive award funds to meet community needs and make the greatest impact.

This toolkit was developed in March 2023 by Homebase, in partnership and with the support of the California Health Care Foundation.

Fundamentals of Homelessness Response for Managed Care Plans[1]

Homebase
with the support of the California Health Care Foundation

The following pages contain foundational information for managed care plans (MCPs) about how homeless assistance works at the local level, including practical, action-oriented suggestions to help MCPs participate in their community's response to homelessness.

What's included

Succinct and to-the-point information and suggested actions to share with MCPs to empower and encourage them to engage and collaborate with their communities' homelessness response systems, whether in the context of the Housing and Homelessness Incentive Program (HHIP) or otherwise:

- The Basics of Continuum of Care (CoC) Structure, Funding, and Operations
- Coordinated Entry (CE): Fundamentals and Opportunities to Leverage CE for Enhanced Care Management, Community Supports, and HHIP Implementation; and
- Practical strategies for MCPs to partner with their local CoCs.

What's not included

Technical details about homeless assistance programs, systems, and operations that often vary from one community to another.

The Basics of Continuum of Care (CoC) Structure, Funding, and Operations

Although federal and state governments fund homelessness response, the work happens at the local, community level. In California, "community level" most often means the geographic area covered by a single county.

County or city governments provide some homeless assistance, but no single agency or organization administers all resources and services. In almost every community across the country, a network of organizations and agencies provide different types of assistance to individuals and families at risk of or experiencing homelessness.

Due to limited resources, the vast majority of housing assistance is prioritized for people living on the street, sleeping in vehicles or tents, or staying in emergency shelters. Communities often further prioritize housing and intensive supportive services for people experiencing "chronic homelessness," which means those who have a disability and have been homeless for more than a year.

Homeless assistance may include:

- Emergency shelter;
- Financial support (one-time assistance or ongoing rental assistance);
- Temporary or permanent housing;
- Supportive services (e.g., case management, assistance applying for benefits, connections to medical or behavioral health care, help finding or securing housing);
- Transportation assistance; and
- Necessities like food.

[1] This tool was adapted from "Homelessness Response 101 for Health Care Providers and Stakeholders," originally developed in February 2021 by Homebase, in partnership and with the support of the California Health Care Foundation.

5 Key Things to Know About CoCs

What is a CoC? Short for "Continuum of Care," CoC is the umbrella term for the group of organizations and agencies (including community-based organizations and local government agencies) that collectively coordinates homeless assistance activities and resources in a community. **A CoC is not a legal entity.** It is a coalition of organizations and entities that meet regularly to discuss and plan their community's homelessness response. There are currently 44 CoCs in California; most cover a single county's geography, but a few cover a single city or two or more adjacent counties. Though CoCs have certain elements in common, the structures, operations, and resources vary from one to the next.

1. **Each CoC designates an entity to apply for federal funds on its behalf.** The designated entity, often a local government agency or non-profit organization, is referred to as the "Collaborative Applicant" or "CoC Lead Agency." It submits the CoC's application for homeless assistance grant funds from the U.S. Department of Housing and Urban Development (HUD). CoCs also must have a Board comprised of representatives from local homeless assistance organizations and at least one person with lived experience of homelessness. A CoC's Board oversees the requirements associated with HUD funding.

2. **HUD awards homeless assistance grant funds to CoCs through an annual competitive process.** Each CoC runs its own local process based on community priorities to determine which local organizations should receive funding from HUD and for what purposes. The CoC Lead Agency uses those determinations to apply for HUD funds on behalf of the community. CoCs (or their partner counties) may also receive California state funding to address homelessness, also in the form of grants; requirements of those funds vary but many are similar to HUD requirements.

3. **Homeless assistance funding is very limited in both amount (relative to need) and eligible uses.** The primary activity CoCs and CoC-funded organizations use HUD funds for is rental assistance to help people exit homelessness through transitional or permanent housing. Some programs combine rental assistance with services for people who need more than financial support to stabilize and maintain housing. Services funding is extremely limited and often isn't able to cover more than case management. Planning, program operations, project administration, and property acquisition, rehab and construction are the only other eligible uses for HUD CoC grant funds. Nearly all eligible HUD funding must be matched with at least a 25% financial or in-kind match.

Types of stakeholders who participate in a CoC include

- Nonprofit homeless assistance providers
- Community- and faith-based organizations
- Victim service providers
- Local government
- Public housing agencies
- School districts
- Social service providers
- **Substance use service organizations and mental health agencies/service organizations**
- Local businesses
- Street outreach teams
- **EMT/crisis response teams**
- **Hospitals**
- Affordable housing developers
- Law enforcement and jail(s)
- **Community health centers and clinics**
- People with lived experience of homelessness
- Organizations that serve specific populations (e.g., veterans, youth, LGBTQ+ people, people with disabilities
- Advocates

4. **The primary purpose of a CoC is to promote a community-wide commitment to end homelessness.** CoC members attend meetings, participate in community-wide planning, and coordinate with each other. While many agencies that participate in a CoC receive HUD funding, entities that do not receive HUD funding still participate in the CoC for a variety of reasons: to increase the impact of their own work; to learn more about the different resources available in the community to better serve their clients; to learn strategies and best practices for responding to homelessness; to build relationships with other leaders and organizations with similar missions and values; to better position themselves for future HUD funding; etc.

5. **HUD requires CoCs to develop certain processes.** Because each community has a variety of assistance programs and resources to support people experiencing or at risk of homelessness, HUD requires every CoC to have a process in place to ensure that people who need housing and other supports are connected to local resources in an equitable and coordinated way. That process is called **Coordinated Entry (CE).**

Basics of Homeless Management Information Systems (HMIS)

What is HMIS?

HUD requires each CoC to collect and report certain information about the people they serve. HMIS (short for Homeless Management Information System) are the data systems communities use to collect and analyze client, service, and housing data. HUD does not mandate that CoCs use a particular software; each community may select any system that can collect the required data elements, comply with HUD's data standards, and support reporting requirements.

Information contained in HMIS

HUD requires every community to track specific data points and response options for various data elements. HUD also publishes data standards that CoCs must meet. Types of required data elements include:

- Basic client information, including whether the client has a physical or developmental disability, chronic health condition, HIV/AIDS, mental health issue, or substance use disorder;
- Whether the client receives non-cash benefits or has health insurance, and if so, what kinds; and
- Information about client interactions with the homelessness response system.

Limitations

Having a single system to collect data about those served by a community's homeless assistance programs is extremely helpful to keep track of clients, coordinate the connection to housing and other resources, monitor client outcomes, and track performance metrics at the organizational and system level. However, the information contained in HMIS can be insufficient for various reasons:

- Only programs that receive HUD funding are required to enter information into a community's HMIS. There can be many programs in a community that assist people experiencing homelessness but do not receive HUD funding (e.g., some faith-based organizations, smaller organizations) and therefore are not required to enter information into HMIS;
- Inconsistent data entry and data quality and missing information often occur with so many different individuals and providers entering data;
- Client information contained in HMIS is largely self-reported and clients may refuse to answer questions or provide incomplete or inaccurate information for a variety of reasons. Clients who underreport their health conditions can result in lower prioritization for housing and resources than their actual vulnerability or acuity of need warrants;
- HMIS is only required to comply with HUD data standards, thus may not meet the standards required under HIPAA; and
- HUD does not provide funding for HMIS to all communities. A CoC must annually prioritize and seek specific funding for HMIS alongside their housing and other programs.

Data Sharing

CoCs must get permission from clients to share their information between providers. Most CoCs accomplish this by asking clients to sign a Release of Information (ROI), which explains why, how, and with whom their information will be shared, as well as the measures taken to protect their information. CoCs maintain lists of provider agencies to which their ROIs apply (usually the list of providers who access and use the local HMIS) and either include that list on the form itself or link to it to allow for easier updating. In some CoCs, MCPs and other health providers already have access to HMIS, although some access is read-only. MCPs without HMIS access should discuss with their local CoCs the possibility of entering into an HMIS agency or provider agreement to help facilitate the kind of data matching or exchange needed to coordinate care and services. Additional ROIs or other Data Sharing agreements may be required to share certain client information, depending on how the CoC's HMIS and existing ROIs are structured. See *Bi-lateral Data Sharing Agreement Between a Continuum of Care and Managed Care Plan* in this Toolkit.

Coordinated Entry Basics

What is Coordinated Entry?

Coordinated Entry (CE) is the process each CoC sets up to ensure people experiencing or at risk of homelessness are prioritized for a community's limited resources based on severity of need. CE also ensures that people are matched to available resources most suitable to meet their needs. **CE's primary purpose is to allocate housing resources fairly and appropriately.** It can also be used to refer and connect people with health care and other mainstream resources. It is critical for MCPs to understand how CE works, both generally and in their local CoCs.

The idea behind Coordinated Entry is **similar to emergency room triage**, which ensures that someone having a heart attack is served before someone with a broken arm, even if the person with the broken arm arrived at the emergency room first and has been waiting for hours. Under Coordinated Entry, higher acuity people are served before lower acuity people. Unlike emergency room care, due to limited available resources, CE does not guarantee that every person who needs housing assistance will receive it.

Benefits of CE

Without CE, people experiencing homelessness have to seek out multiple individual organizations that might be able to help them. In addition to being extremely burdensome for people already in crisis, individuals able to manage the burden often end up on numerous separate waitlists for housing.

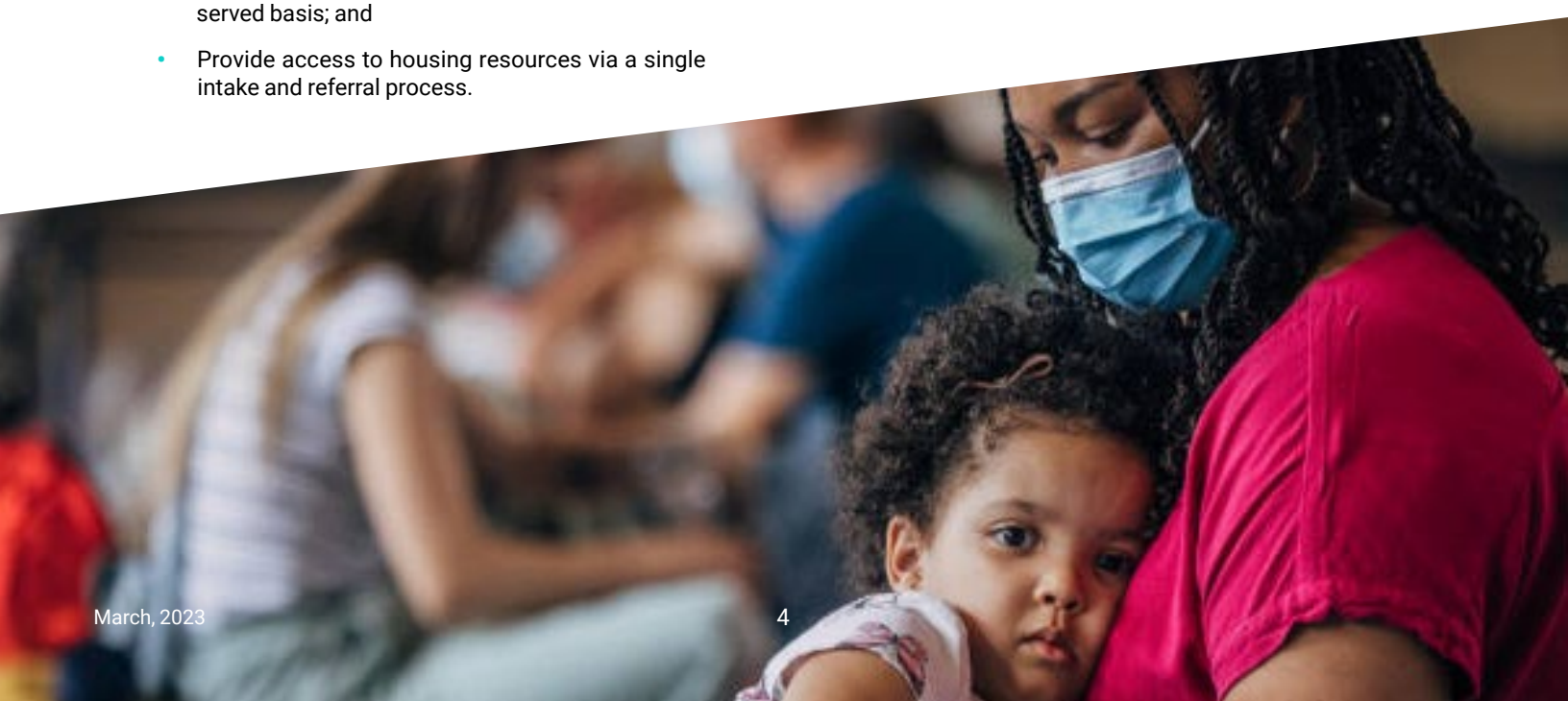
CE removes reliance on individual program waitlists organized on a first-come, first-served basis that do not take acuity of need into account. Instead, CE focuses on acuity of need so the individuals and families in the most dire of circumstances can be housed before those in less need. It also helps people more quickly learn about and get connected to different types of assistance beyond housing (e.g., public benefits, health coverage, or employment help). With CE, a person's access to resources does not depend on the individual case manager assigned (if any) or a person or family's own ability to navigate complicated systems.

CE Requirements

With CE, HUD mandates that each CoC:

- Use a standardized assessment approach with every individual or household that needs housing assistance to determine vulnerability, needs, and eligibility for resources;
- Organize a community-wide waitlist for housing resources that prioritizes individuals and families based on vulnerability/severity of need rather than on a first-come, first-served basis; and
- Provide access to housing resources via a single intake and referral process.

A well-functioning CE process ensures: (1) limited housing resources are prioritized to those most in need because of health issues, vulnerability to death or victimization, or the circumstances of their homelessness; and (2) people seeking housing are more likely to be matched with resources that meet their specific needs, regardless of where, when, or how they "show up" seeking assistance.



5 Key Things to Know about CE

1. **CE is required.** Every CoC must operate a CE system as a condition of receiving HUD funding. Every organization that receives HUD's homeless assistance grant funding must participate in CE. All housing vacancies and rental assistance vouchers funded with HUD's homeless assistance grant funding must be filled through the CE process.

2. **Key Components of CE** (1) Intake: entry by each person into the CE system; (2) Assessment of each person; (3) Prioritization of every assessed person based on vulnerability/severity of need; (4) A process to match resources to individuals or families as they become available, based on the established prioritization; (5) Referrals to housing programs that provide the matched resources; and (6) Placement of people into the housing programs to which they've been referred.

3. **CoCs have flexibility in designing their CE processes.** Every CoC's CE process must meet certain requirements, but CoCs have flexibility to customize their process. Based on local capacity, needs, and resources, each CoC must plan and design (1) how and where to identify people in need of homeless assistance; (2) what tool(s) to use to assess each person or family; (3) what factors to include when determining relative vulnerability of those assessed (i.e., the information on which to base prioritization); (4) the process and people involved to match available resources to prioritized people and connect those people to the agencies who hold the resources; and (5) how to evaluate whether the process is working well.

4. **CE is open to all organizations that serve people experiencing homelessness.** Only HUD-funded programs are required to participate, but the goal is for all local organizations with resources for people experiencing homelessness to participate, regardless of funding source. CE can be used to refer individuals and households to health care and other mainstream services and resources in addition to housing assistance.

5. **CoCs must evaluate and refine their CE processes to center equity, address disparities, and improve outcomes**. Although HUD has mandated CE for multiple years, CoCs are at different points in implementation. CoCs should regularly make adjustments to ensure the process is working effectively and equitably. Even in communities with an established CE system, there is always room for discussions, planning, and changes to improve implementation. Partners with diverse perspectives and expertise - including MCPs and other health system partners - are critical to identify issues, offer new insights, and inform changes.

Key Components of Coordinated Entry

System Entry
People seeking housing or services make contact with the community's homelessness response system, usually by interacting with an outreach worker, calling 211, or showing up at a service provider site.

Assessment
All individuals and families who enter the system are assessed in a consistent manner, using a uniform decision-making process and standardized assessment tools.

Prioritization
People are prioritized for housing and community resources based on factors agreed upon by the CoC, ensuring limited resources are used in the most effective manner and households most in need of assistance are prioritized for housing and services.

Matching
As housing resources become available, people at the top of the community's priority list are given a choice to accept those resources for which they are eligible and which appear to meet their needs.

Referral
People matched with a resource are referred to the program holding that resource, which requires communication between those who made the match decision, the person being referred, and the program providing the resource.

Placement
People are placed into the program and ultimately into housing. This usually entails ensuring the person is "document-ready" and often requires the person, program, and other partners to work together to address various barriers to housing placement and stability.

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Assessments

Relevant assessment factors include information about each person's needs, strengths, preferences, barriers they face to secure housing, length and duration of past and current episodes of homelessness, and characteristics that make them more vulnerable while experiencing homelessness. Most assessment information is self-reported and people may under-report certain conditions for various reasons.

Prioritization

Prioritization schemes are decided by each community and usually take into account the severity of service needs, considering factors such as risk of illness, death, and/or victimization; history of high utilization of crisis services; and significant physical or mental health challenges, substance use disorders, or functional impairments.

Opportunities to Leverage CE to support ECM, CS, and HHIP Implementation

Coordinated Entry (CE) offers practical and meaningful opportunities for cross-system coordination. By plugging into a community's CE process, MCPs can (1) ensure members with housing needs connect to the homelessness response system in the way most likely to get them assessed, prioritized, and connected to available resources; (2) ensure members are made aware of and referred to benefits and services like Enhanced Care Management (ECM) and Community Supports (CS); and (3) contribute valuable expertise to improve the overall CE process over time so both housing and Medi-Cal resources get to those who need them most in an efficient and equitable way.

Each improvement to the CE process and each member connection to housing resources or Medi-Cal benefits contributes to improved member outcomes and decreased burdens on the health system. **The following are examples of ways MCPs (or their contracted providers) can participate in CE and contribute to its improved functioning.**

System Entry

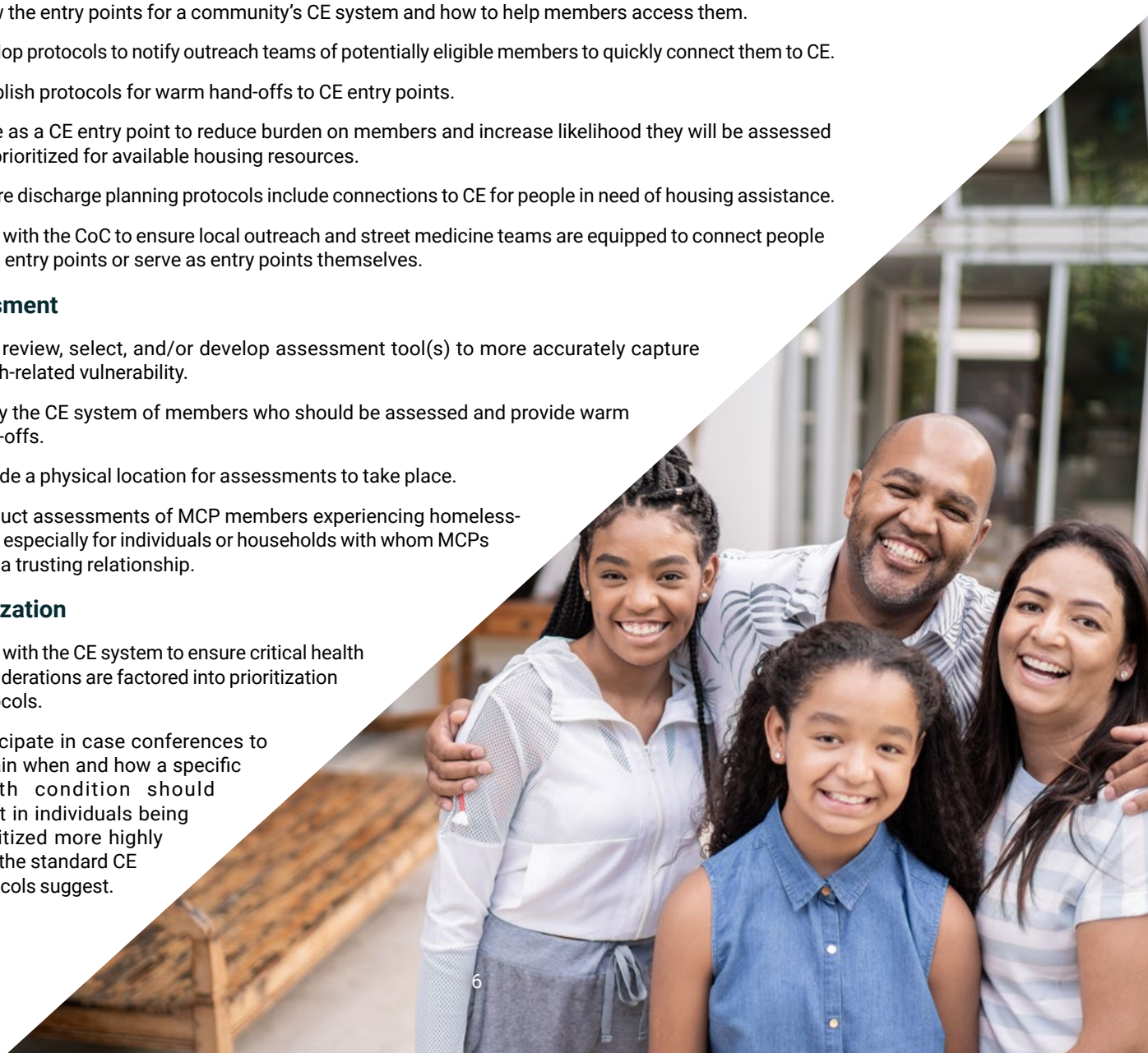
- Learn to identify members experiencing or at risk of homelessness to connect to the CE system.
- Know the entry points for a community's CE system and how to help members access them.
- Develop protocols to notify outreach teams of potentially eligible members to quickly connect them to CE.
- Establish protocols for warm hand-offs to CE entry points.
- Serve as a CE entry point to reduce burden on members and increase likelihood they will be assessed and prioritized for available housing resources.
- Ensure discharge planning protocols include connections to CE for people in need of housing assistance.
- Work with the CoC to ensure local outreach and street medicine teams are equipped to connect people to CE entry points or serve as entry points themselves.

Assessment

- Help review, select, and/or develop assessment tool(s) to more accurately capture health-related vulnerability.
- Notify the CE system of members who should be assessed and provide warm hand-offs.
- Provide a physical location for assessments to take place.
- Conduct assessments of MCP members experiencing homelessness, especially for individuals or households with whom MCPs have a trusting relationship.

Prioritization

- Work with the CE system to ensure critical health considerations are factored into prioritization protocols.
- Participate in case conferences to explain when and how a specific health condition should result in individuals being prioritized more highly than the standard CE protocols suggest.



Matching

- Participate in matching case conferences to provide additional facts about members that might increase the likelihood of appropriate and successful housing resource matches.
- Help members understand their options and how each might impact health care access and outcomes.
- Educate CE system operators on Medi-Cal benefits and services available to people experiencing or at risk of homelessness, including eligibility criteria.

Referral

- Offer support to housing providers and their clients (e.g., provide health care or other services to clients) to increase the likelihood that referred members are accepted and successful in housing placements.
- Help members procure necessary eligibility documentation (e.g., disability verification) so they can more quickly access housing.
- Educate CE system partners/providers on Medi-Cal enrollments and work with them to facilitate Medi-Cal enrollments so that more people experiencing homelessness have health coverage.
- Educate CoC/CE system operator and providers on the referral processes for Medi-Cal benefits and services and work with them to streamline those referrals through CE.

Placement

- Provide transportation help to get clients to appointments.
- Follow up with housed members to ensure continued connections to health care needed to support long-term housing stability.

Connecting with your Local CoC

There's no one way to collaborate with a CoC or participate in a Coordinated Entry system that applies across the board. Each CoC has different things to offer and needs different things from potential health care partners. Specific opportunities to partner with CoCs (whether in the context of HHIP implementation or otherwise) vary across CoCs as well.

The best way to engage with your local CoC(s) in a mutually beneficial way is to connect with and begin to build a relationship with representatives from key CoC stakeholders such as the Lead Agency, CoC Chair, or Coordinated Entry operator. Remember that while a county agency might serve as one or more of those roles, that's not always the case. Speaking with CoC and CE leaders is a great way to learn about the health needs of people who engage with your local homelessness response system, share insights about your and your members' needs, and discuss opportunities for cross-system collaboration and partnership to address those needs.

A list of all California CoCs and their websites is available here.

California Continuums of Care by County

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County or City	Name of CoC	CoC Website
Alameda County	Oakland, Berkeley/Alameda County CoC	everyonehome.org/about/committees/hud-coc-committee
Alpine County	Alpine, Inyo, Mono Counties CoC	www.imaca.net
Amador County	Amador, Calaveras, Mariposa, Tuolumne Counties CoC (Central Sierra CoC)	www.atcaa.org
Butte County	Chico, Paradise/Butte County CoC	www.buttecaa.com
Calaveras County	Amador, Calaveras, Mariposa, Tuolumne Counties CoC (Central Sierra CoC)	www.atcaa.org
City of Glendale	Glendale CoC	www.glendaleca.gov/government/departments/community-services-parks/human-services/homeless-services/glendale-continuum-of-care-social-service-agencies
City of Long Beach	Long Beach CoC	www.longbeach.gov/health/services/directory/homeless-services
City of Pasadena	Pasadena CoC	pasadenapartnership.org/coc-program
Colusa County	Colusa, Glenn, Trinity Counties CoC (aka Dos Rios CoC)	www.countyofglenn.net/dept/community-action/dos-rios-continuum-care-ca-523
Contra Costa County	Richmond/Contra Costa County CoC	cchealth.org/h3/coc/council.php
Del Norte County	Redding/Shasta, Siskiyou, Lassen, Plumas, Del Norte, Modoc, Sierra Counties CoC (NorCal CoC)	www.shastacounty.gov/housing-community-action-programs/page/norcal-continuum-care
El Dorado County	El Dorado County CoC	www.edokcoc.org
Fresno County	Fresno City and County/Madera County CoC	fresnomaderahomeless.org
Glenn County	Colusa, Glenn, Trinity Counties CoC (aka Dos Rios CoC)	www.countyofglenn.net/dept/community-action/dos-rios-continuum-care-ca-523
Humboldt County	Humboldt County CoC	humboldtgov.org/2512/Humboldt-Housing-Homeless-Coalition
Imperial County	Imperial County CoC	www.imperialvalleycontinuumofcare.org
Inyo County	Alpine, Inyo, Mono Counties CoC	www.imaca.net
Kern County	Bakersfield/Kern County CoC	bkrhc.org
Kings County	Visalia/Kings, Tulare Counties CoC	www.kthomelessalliance.org
Lake County	Lake County CoC	www.lakecoc.org
Lassen County	Redding/Shasta, Siskiyou, Lassen, Plumas, Del Norte, Modoc, Sierra Counties CoC (NorCal CoC)	www.shastacounty.gov/housing-community-action-programs/page/norcal-continuum-care

[1] If a listed website has changed since this material was finalized, using the following search terms in an online search engine should help you find the updated website: [county's name] + continuum of care + homeless

Geography Covered	Name of CoC	CoC Website
Los Angeles County (except the cities of Glendale, Long Beach, and Pasadena)	Los Angeles City & County CoC	www.lahsa.org
Madera County	Fresno City and County/Madera County CoC	fresnomaderahomeless.org
Marin County	Marin County CoC	www.marinhhs.org/homelessness-marin
Mariposa County	Amador, Calaveras, Mariposa, Tuolumne Counties CoC (Central Sierra CoC)	www.atcaa.org
Mendocino County	Mendocino County CoC	mendocinococ.org/continuum-of-care
Merced County	Merced City & County CoC	www.co.merced.ca.us/848/Homeless-Assistance
Modoc County	Redding/Shasta, Siskiyou, Lassen, Plumas, Del Norte, Modoc, Sierra Counties CoC (NorCal CoC)	www.shastacounty.gov/housing-community-action-programs/page/norcal-continuum-care
Mono County	Alpine, Inyo, Mono Counties CoC	www.imaca.net
Monterey County	Salinas/Monterey, San Benito Counties CoC	chsp.org
Napa County	Napa City and County CoC	www.countyofnapa.org/1036/Napa-Continuum-of-Care
Nevada County	Nevada County CoC	www.countyofnapa.org/1036/Napa-Continuum-of-Care
Nevada County	Nevada County CoC	www.hrcscoc.org
Orange County	Santa Ana, Anaheim/Orange County CoC	www.ochealthinfo.com/homeless_serv/coc/2021
Placer County	Roseville, Rocklin/Placer County CoC	www.hrcscoc.org
Plumas County	Redding/Shasta, Siskiyou, Lassen, Plumas, Del Norte, Modoc, Sierra Counties CoC (NorCal CoC)	www.shastacounty.gov/housing-community-action-programs/page/norcal-continuum-care
Riverside County	Riverside City and County CoC	dpss.co.riverside.ca.us/homeless-programs/housing-and-homeless-coalition
Sacramento County	Sacramento City & County CoC	sacramentostepsforward.org
San Benito County	Salinas/Monterey, San Benito Counties CoC	chsp.org
San Bernardino County	San Bernardino City & County CoC	sbcountycdha.com/community-development-and-housing-department/homelessness
San Diego County	San Diego City and County CoC	www.rtfhsd.org
San Francisco County	San Francisco CoC	hsh.sfgov.org/committees/lhcb
San Joaquin County	Stockton/San Joaquin County CoC	www.sanjoaquincoc.org
San Luis Obispo County	San Luis Obispo County CoC	www.slocounty.ca.gov/Departments/Social-Services/Homeless-Services.aspx

Geography Covered	Name of CoC	CoC Website
San Mateo County	Daly City/San Mateo County CoC	hsa.smcgov.org/san-mateo-county-continuum-care
Santa Barbara County	Santa Maria/Santa Barbara County CoC	www.countyofsb.org/443/Continuum-of-Care-Program
Santa Clara County	San Jose, Santa Clara City & County CoC	osh.sccgov.org/continuum-care
Santa Cruz County	Watsonville/Santa Cruz City & County CoC	homelessactionpartnership.org
Shasta County	Redding/Shasta, Siskiyou, Lassen, Plumas, Del Norte, Modoc, Sierra Counties CoC (NorCal CoC)	www.shastacounty.gov/housing-community-action-programs/page/norcal-continuum-care
Sierra County	Redding/Shasta, Siskiyou, Lassen, Plumas, Del Norte, Modoc, Sierra Counties CoC (NorCal CoC)	www.shastacounty.gov/housing-community-action-programs/page/norcal-continuum-care
Siskiyou County	Redding/Shasta, Siskiyou, Lassen, Plumas, Del Norte, Modoc, Sierra Counties CoC (NorCal CoC)	www.shastacounty.gov/housing-community-action-programs/page/norcal-continuum-care
Solano County	Vallejo/Solano County CoC	www.housingfirstsolano.org
Sonoma County	Santa Rosa, Petaluma/Sonoma County CoC	sonomacounty.ca.gov/CDC/Homeless-Services/Continuum-of-Care
Stanislaus County	Turlock, Modesto/Stanislaus County CoC	csocstan.com/about
Sutter County	Yuba City and County/Sutter County CoC	www.syhomelessconsortium.org
Tehama County	Tehama County CoC	www.tehamacoc.org
Trinity County	Colusa, Glenn, Trinity Counties CoC (aka Dos Rios CoC)	www.countyofglenn.net/dept/community-action/dos-rios-continuum-care-ca-523
Tulare County	Visalia/Kings, Tulare Counties CoC	www.kthomelessalliance.org
Tuolumne County	Amador, Calaveras, Mariposa, Tuolumne Counties CoC (Central Sierra CoC)	www.atcaa.org
Ventura County	Oxnard, San Buenaventura/Ventura County CoC	www.venturacoc.org
Yolo County	Davis, Woodland/Yolo County CoC	www.y3c.org
Yuba County	Yuba City and County/Sutter County CoC	www.syhomelessconsortium.org

Understanding HHIP Performance Metrics

Homebase
with the support of the California Health Care Foundation

This resource summarizes the performance measurements for each HHIP metric for Performance Measurement Period 2, and the information MCPs need to provide to DHCS by December 2023. It is intended to help CoCs better understand DHCS's expectations so they can partner more effectively with their local MCPs to maximize the HHIP incentive award funds available in their local communities.

As explained in greater detail in the Homebase-developed resource, "The Housing & Homelessness Incentive Program (HHIP)," to receive payments of HHIP incentive funds, MCPs must file reports to the Department of Health Care Services (DHCS) at the end of each of two measurement periods and demonstrate that they have met specific DHCS performance metrics. The reports for Measurement Period 1 (covering May 1, 2022-December 31, 2022) were due March 10, 2023. Measurement Period 2 reports (covering January 1, 2023-October 31, 2023) are due in December 2023.

While on its face, HHIP is a program to incentivize MCPs, it has the potential to result in significant additional investment (of funding and other resources) in local community efforts to prevent and end homelessness. Collaboration between CoCs and MCPs can increase the potential to meet DHCS metrics and maximize the amount of incentive funds awarded to MCPs and available to invest back into the community's homelessness response. CoCs may be aware of DHCS' HHIP Priority Areas and the 15 metrics they will use to evaluate MCPs, but most are not familiar with the specific information DHCS requests for each metric and how they define performance measurements.

Meeting Performance Metrics

HHIP metrics are either Pay for Performance or Pay for Reporting.

Pay for Performance means MCPs must demonstrate their performance, usually by submitting numerical data, to earn points toward incentive funds.

Pay for Reporting means MCPs are awarded points for a narrative report containing requested information, rather than for meeting a specific performance measure.

HHIP Metrics & How DHCS is Measuring MCP Performance

DHCS evaluates MCPs seeking HHIP incentive funds based on how they meet the priority areas and all 15 metrics. They have identified 7 high priority metrics, indicated with red font below, which can earn MCPs additional points.

The following pages provide details about each of the 15 performance metrics, including:

- A brief description of each metric;
- What MCPs are required to report to DHCS;
- How DHCS defines and measures full performance of each metric; and
- Ways CoCs can help ensure MCPs meet the metric.

Metric 1.1: Engagement with the local CoC

MCPs must engage with the CoC in various ways to improve partnership and collaboration. Engagement may include, but is not limited to:

- Attending CoC meetings;
- Joining the CoC Board;
- Joining a CoC subgroup or workgroup; and/or
- Attending a CoC webinar.

MCPs initially submitted a Local Homeless Plan (LHP) to DHCS in mid-2022 that included the types and percentages of CoC meetings they would attend (e.g., 100% of CoC membership meetings or Coordinated Entry Work Group meetings).

Information required

The number and type of meetings held during the measurement period that MCPs said they would attend and the number they actually attended during the measurement period.

MCPs must also describe any engagement with other city and county housing and homelessness partners (including social services, housing development agencies, Public Housing Authorities, and health services and public health), including efforts to coordinate data, referrals, and service delivery.

To meet the performance measurement

This is a Pay for Performance Metric; MCPs must have attended 100% of the meetings that they said in their LHP they would attend.

How CoCs can assist

How well the MCP can meet this measure depends on what they committed to in the LHP. CoCs should check with their local MCPs about their LHP commitments and ensure MCPs are aware of and invited to all relevant meetings. Working with MCPs to ensure they understand the purpose of each type of meeting and discussing ways they can actively participate will encourage attendance and also ensure their attendance is mutually beneficial and productive.

Metric 1.2: Connection and integration with the local Coordinated Entry System

MCPs need to better understand the Coordinated Entry (CE) System in each county where they operate, consider becoming CE access points, coordinate with the CoC on members' housing needs, and make and receive referrals where appropriate. In their LHP, MCPs reported to DHCS the feasibility of becoming a CE access point. In their Measurement Period 1 report, MCPs submitted an action plan based on that feasibility assessment.

Information required

A narrative description of updates made to the CE process as a result of the MCP's involvement, including how health factors and risks have been incorporated into the CE assessment and prioritization process, as well as the MCP's progress toward becoming a CE access point based on the action plan submitted as part of their Measurement Period 1.

To meet the performance measurement

This is a Pay for Reporting metric; MCPs are awarded for the narrative description on progress.

How CoCs can assist

Work with their local MCPs to explain how CE works locally and discuss the possibility and desirability of them becoming access points or ensuring their members experiencing homelessness are referred to access points. CoCs and MCPs should discuss the health-related factors that can be incorporated into CE prioritization and assessment processes to improve the overall equity and operation of CE. CoCs might:

- Invite MCPs to participate in CE committees;
- Invite MCPs to review CE policies and procedures and the prioritization protocol;
- Develop and add medical vulnerability screening questions into CE intake procedures in partnership with their local health partners;
- Revise prioritization to include medical vulnerability factors;
- Train MCP staff and their contracted providers about CE and how it works in the community; and
- Support MCPs or their contracted providers to become CE access points or assessors, as appropriate.

Metric 1.1 Formula:

$$\frac{\text{\# of relevant meetings MCP attended during time period}}{\text{Total \# of relevant meetings held during time period}}$$

Example

In its LHP, the MCP committed to attend all CoC Board Meetings, General Membership meetings, CE committee meetings, HMIS data sharing meetings, and strategic planning meetings.

Between Jan 1, 2023 and October 31, 2023: The MCP attended 6 CoC Board meetings, 1 CoC General Membership meeting, 2 CE Committee meetings, 4 HMIS Data Sharing meetings, and 1 Strategic Planning meeting.

The CoC held a total of 19 total meetings: 8 Board meetings, 1 CoC General Membership meeting, 4 CE meetings, 4 HMIS Data Sharing meetings, and 2 Strategic Planning meetings.

The percentage of relevant meetings the MCP attended = 73% (14/19) so the MCP would not satisfy DHCS's 100% participation requirement.

Metric 1.3: Identifying and addressing barriers to providing Community Supports and other housing-related services to MCP members experiencing homelessness.

MCPs must identify and address barriers to providing medically appropriate and cost-effective housing-related Community Supports (CS) services or other housing-related services to MCP members experiencing homelessness.

Information required

MCPs must explain the approach they took to address barriers described in their LHPs, as well as information on the sustainability of the approach and how the MCP will continue to address the barriers beyond HHIP.

To meet the performance measurement

This is a Pay for Reporting metric.

How CoCs can assist

Provide insight to MCPs on strategies and approaches most likely to help overcome existing barriers for people experiencing homelessness to access housing-related CS and other services. CoCs might:

- Train CoC housing and service providers to refer and connect individuals experiencing homelessness to CS services;
- Track data about CS referrals;
- Follow up with housing and service providers on the success rates of connecting individuals experiencing homelessness to CS; and
- Facilitate trainings and case conferences between MCP CS providers and homeless services providers.

Metric 1.4: Partnerships with counties, CoCs, and other organizations that deliver housing services with which the MCP has a data sharing agreement that allows for timely exchange of information and member matching.

MCPs need to exchange information and conduct member matching on a timely basis with counties, CoCs, and organizations that they contract with to deliver housing services (i.e., interim housing, rental assistance, supportive housing, outreach, prevention/diversion). Specifically, MCPs must be able to access information about their members' housing status.

Information required

The total number of providers that the MCP has contracted with to deliver housing-related services and the number of those providers who are actively sharing MCP member housing status information under a local Data Sharing Agreement (DSA) or California's Data Exchange Framework Data Sharing Agreement. If the DSA is through an intermediary, the MCP must be able to access the members' information related to their housing status.

To meet the performance measurement

This is a Pay for Performance Metric. At least 75% of the providers the MCP has contracted with to deliver housing-related services must be actively sharing MCP member housing status information.

How CoCs can assist

Work with their local MCPs to develop a DSA that facilitates information exchange and member matching between HMIS and MCP client records. Identify the process required to engage in data exchange and provide sufficient time to engage in that process. CoCs can ensure the MCPs are able to access member housing status information for all HMIS-participating providers. Seek bi-lateral data exchange so information about clients is coming back to the CoC, which can facilitate housing stability.

Metric 1.5: Data sharing agreement with county mental health plans and drug Medi-Cal organization delivery system

MCPs must have DSAs in place with county Mental Health Plans (MHP) or Drug Medi-Cal Organized Delivery System (DMC-ODS) – if applicable – that includes the ability to perform member matching and sharing information on housing status.

Information required

MCPs must report whether they have a DSA in place with county MHPs or DMC-ODS (if applicable) that includes the ability to do member matching and information sharing on member housing status.

To meet the performance measurement

This is a Pay for Performance Metric. MCPs must have an agreement in place as described above.

How CoCs can assist

As this is an agreement with county partners, CoCs are unlikely to be involved.

Metric 1.6: Partnerships and strategies the MCP will develop to address disparities and equity in service delivery, housing placements, and housing retention

MCPs must develop strategies and partnerships to address disparities and equity in service delivery, housing placements, and housing retention. In their LHPs, MCPs provided a narrative description of how they planned to work with housing partners to identify: 1) disparities and inequities that currently exist in the county related to housing; and 2) their approach to partnering with local organizations to address the stated disparities and inequities as they relate to service delivery, housing placements, and housing retention.

Information required

A narrative evaluation of the MCP's implementation of partnerships with local organizations to address the disparities and inequities they included in their LHPs.

To meet the performance measurement

This is a Pay for Performance Metric. MCPs must have fully implemented the approach they described in their LHPs.

How CoCs can assist

CoCs can share their goals and progress to address disparities and inequities, especially from their Homeless Housing, Assistance and Prevention (HHAP) grants. They can review the approaches MCPs outlined in their LHPs and suggest ways they can partner to address the identified disparities and inequities.

Metric 1.7: Lessons learned from development and implementation of the Investment Plan

MCPs were required to develop an Investment Plan in collaboration with their local CoCs and/or counties to outline the investments they planned to make to ensure they met the HHIP metrics. MCPs were expected to work with their local CoCs to implement the Investment Plans. This metric aims to elicit information about the success of the investments and what the MCPs learned from developing and implementing the Investment Plans.

Information required

A narrative description outlining:

- Which investments were successful in progressing the HHIP program goals (i.e., to ensure MCPs have the necessary capacity and partnerships to connect their members to needed housing services and reduce and prevent homelessness);
- Which investments were not successful in progressing the HHIP program goals;
- Lessons learned from developing and implementing the Investment Plan; and
- Which investments have the capacity to sustain HHIP program goals going forward, and alignment with ongoing CalAIM efforts.

To meet the performance measurement

This is a Pay for Reporting metric.

How CoCs can assist

CoCs and MCPs can partner to evaluate each activity and investment. CoCs can share any data and success stories about the impact of the investment. CoCs and MCPs can discuss which investments should be sustained going forward. CoCs can share their insights regarding lessons learned in working to implement their Local Homeless Plans and Investment Plans.

Metric 2.1: Connection with street medicine team providing health care for individuals who are homeless

Street Medicine is defined as health and social services developed specifically to address the unique needs and circumstances of unsheltered homeless individuals delivered directly to these individuals in their own environment. See *Medi-Cal and HHIP Coverage for Street Medicine* in this Toolkit. This metric is aimed at ensuring MCP members experiencing homelessness can access care via street medicine programs.

Information required

The percentage of MCP members experiencing homelessness during the measurement period who received care from the MCP's street medicine partner (or for MCPs operating in a designated rural county where a street medicine team is not present, the alternative services provided directly by the MCP).

To meet the performance measurement

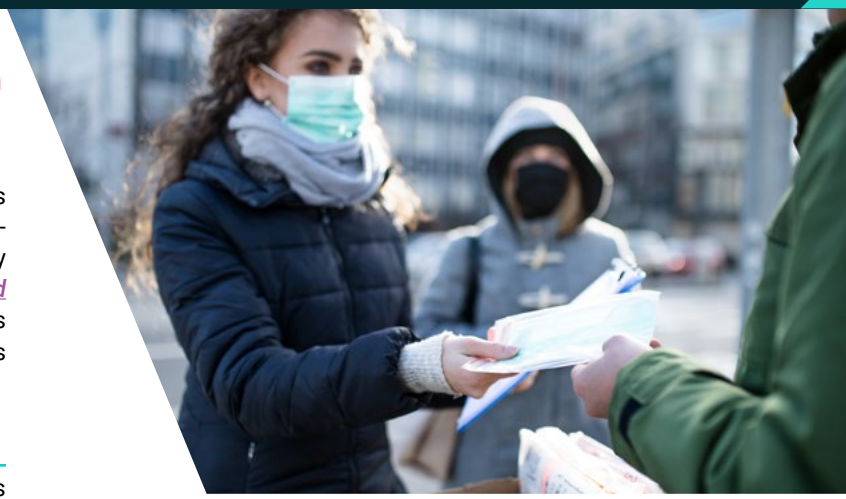
This is a Pay for Performance Metric. MCPs must report a 10% increase as compared to Measurement Period 1 submission.

How CoCs can assist

CoCs can collaborate with MCPs to identify their current street medicine programs, if any. They can make connections with health care providers who either have street medicine programs or would be open to participating in street medicine with associated funding. CoCs can share best practices with MCPs on how they coordinate street outreach, which can be applied to street medicine efforts. They can also connect street outreach teams to partner with street medicine providers. They can strategize with MCPs on what is needed to begin or expand street medicine so that additional people are able to access street medicine services. This may require additional financial investment (e.g., staffing or technology to accurately track service provision), which MCPs can provide.

Street Medicine

The 10% increase must be the proportion of members experiencing homelessness who have received street medicine services. For example: If 10% of the MCP's members experiencing homelessness were served via street medicine during Measurement Period 1, 20% of the MCP's members experiencing homelessness must be served via street medicine during Measurement Period 2. It would not necessarily be enough for the number of members served via street medicine to increase by 10% (e.g., 100 people served during Measurement Period 1 and 110 during Period 2).



Metrics 2.2: MCP connection with the local Homeless Management Information System (HMIS)

A critical component of HHIP is the ability of MCPs to work with their local CoCs to leverage the information contained in the local HMIS, ideally through direct access or data sharing and exchange.

Information required

Whether the MCP has the ability to:

1. Receive timely alerts from their local HMIS when an MCP's member experiences a change in housing status; and
2. Match their member information with HMIS client information.

MCPs must also describe their process to translate the timely alerts into supporting referrals for CS from CoCs and other housing providers.

To meet the performance measurement

The first two elements are Pay for Performance. The MCP must answer yes to both. The element of translating timely alerts into CS referrals is a Pay for Reporting Metric; MCPs are awarded for reporting on their process.

How CoCs can assist

CoCs can work with their MCPs to provide direct access to HMIS that is more than read-only or enter into DSAs to facilitate both member matching and alerts of housing status changes for MCP members. See *Bi-lateral Data Sharing Agreement Between a Continuum of Care and Managed Care Plan* and *Sample Workflow for Continuums of Care and Managed Care Plans to Conduct a Client Data Match* in this Toolkit. See also: Breaking Down Silos: How to Share Data to Improve the Health of People Experiencing Homelessness and How to Share Data: A Practical Guide for Health and Homeless Systems of Care.

Metric 2.3: MCP process for tracking and managing referrals for the housing-related Community Supports it is offering during the measurement period

MCPs can elect to offer their members a variety of Community Supports (CS), several of which are housing-related: housing transition navigation, housing deposits, housing tenancy and sustaining services, recuperative care/medical respite, short-term hospitalization housing, and day habilitation programs. MCPs contract with providers to deliver CS services. When eligible members are referred for a Community Support, they are assigned a CS provider, who should then follow up with the member and ultimately deliver CS services.

Information required

The percentage of their contracted housing-related CS providers who electronically received, followed up, and closed a housing-related CS referral.

To meet the performance measurement

This is a Pay for Performance Metric. MCPs must report a 5% increase from their Measurement Period 1 submission. MCPs are evaluated based only on the Community Supports they offered during the measurement period.

How CoCs can assist

Work with MCPs to integrate housing-related CS referrals into CE or HMIS to help facilitate and track those referrals electronically. To read additional ways to ensure eligible MCP members are connected to available housing-related Community Supports, see *Maximizing CalAIM's Enhanced Care Management (ECM) Benefit and Community Supports (CS) Services* in this Toolkit.

Community Supports

The 5% increase must be in the proportion of contracted housing-related CS providers who electronically received, followed up, and closed a housing-related CS referral. For example: If during Measurement Period 1, an MCP had contracts with 20 organizations to provide housing-related CS services and 2 (or 10%) of them electronically received, followed up, and closed a housing-related CS referral, to meet this performance measurement for Period 2, at least 15% of the MCP's contracted housing-related CS providers would need to have done so.

Metric 3.1: Percent of MCP Members screened for homelessness/risk of homelessness

MCPs must know which of their members are experiencing or at risk of homelessness to ensure they are connecting people to needed housing-related services. This metric also encourages MCPs to connect their members in need of housing-related services directly to the CoC's CE to be assessed, prioritized, and connected to CoC resources.

Information required

The percentage of MCP members who were screened for homelessness or risk of homelessness during the measurement period.

To meet the performance measurement

This is a Pay for Performance Metric. MCPs must report a 5% increase from their Measurement Period 1 submission.

How CoCs can assist

Educate MCPs on effective and trauma-informed ways to screen their members for homelessness. CoCs can also have outreach teams or other CoC providers screen members they work with and can offer to train MCP staff on trauma-informed care.

Screened for Homelessness

The 5% increase must be in the proportion of MCP members screened. For example, if the MCP had 5,000 members during Measurement Period 1 and screened 200 (or 4%) during that time period, they would have to screen at least 9% of their members during Measurement Period 2.

Metric 3.2: MCP Members who were discharged from an inpatient setting or have been to the emergency department for services two or more times in a 4-month period who were screened for homelessness or risk of homelessness

This metric is a subset of Metric 3.1, specific to MCP members who are discharged from an inpatient setting or in the emergency department for services two or more times over four consecutive months.

Information required

The percentage of MCP members who were discharged from an inpatient setting or in the emergency department for services two or more times over four consecutive months who were screened for homelessness or risk of homelessness during Measurement Period 2.

To meet the performance measurement

This is a Pay for Performance Metric. MCPs must report a 5% increase from their Measurement Period 1 submission.

How CoCs can assist

Partner with MCPs to create hospital liaison positions within a homeless service provider. Liaisons can partner with local hospitals and provide support and education on treating, triaging, and identifying people experiencing homelessness who use emergency department services.

Metric 3.3: MCP members experiencing homelessness who were successfully engaged in ECM

An important goal of HHIP is to connect people experiencing homelessness who are eligible for Enhanced Care Management (ECM) to that benefit. This metric evaluates whether MCP members are successfully referred to and receiving the benefit.

Information required

The percentage of MCP members experiencing homelessness engaged in ECM during Measurement Period 2.

To meet the performance measurement

This is a Pay for Performance Metric. MCPs must report a 5% increase from their Measurement Period 1 submission.

How CoCs can assist

Educate CoC members about ECM. CoCs can collaborate with MCPs to provide information to homeless service providers that describe the process for making ECM referrals. See *Maximizing CalAIM's Enhanced Care Management (ECM) Benefit and Community Supports (CS) Services* in this Toolkit.

Metric 3.4: MCP members experiencing homelessness receiving at least one housing-related Community Support

Similar to Metric 3.3, this metric focuses on ensuring people experiencing homelessness who are eligible for housing-related Community Supports (CS) are successfully referred to and receiving at least one of the housing-related CS services.

Information required

The percentage of MCP members experiencing homelessness who received at least one of the MCP's offered housing-related CS services (housing transition navigation, housing deposits, housing tenancy and sustaining services, recuperative care/medical respite, short-term post-hospitalization housing, or day habilitation programs) during Measurement Period 2.

To meet the performance measurement

This is a Pay for Performance Metric. MCPs must demonstrate a 5% increase from Submission 1 or their LHP (whichever of the two reported a higher percentage).

How CoCs can assist

Educate their providers about the specific CS services offered by their local MCPs. CoCs can collaborate with MCPs to provide information to homeless service providers that describe the process for making CS referrals. They can encourage their housing service providers to apply to become CS providers. See *Maximizing CalAIM's Enhanced Care Management (ECM) Benefit and Community Supports (CS) Services* in this Toolkit.

Metric 3.5: MCP Members who were successfully housed

MCPs reported on the percentage of their members experiencing homelessness during the 8-month measurement period 1 (May-Dec. 2022) who were successfully housed during that time. For Measurement Period 2, MCPs must show an improvement in their ability to help successfully house their members.

Information required

The percentage of MCP members who experienced homelessness during the 10-month measurement period 2 (Jan.-Oct. 2023) who were successfully housed during that time; partial points will be awarded for significant improvement that is less than 25%.

To meet the performance measurement

This is a Pay for Performance Metric. MCPs must report at least 25% improvement from Submission 1 for full points; partial points will be awarded for significant improvement that is less than 25%.

DHCS provided MCPs with guidance on the definition of "successfully housed" for purposes of the metric. In brief, "successfully housed" includes situations in HMIS that CoCs typically designate as permanent housing, as well as community-based housing without a designated length of stay, permanent supportive housing (PSH) and other service-enriched affordable housing, and rapid rehousing (RRH). It does not include crisis housing, emergency shelter, transitional housing, bridge (reserved crisis) housing, or other living situations that CoCs do not consider permanent housing. For DHCS's full description of "successfully housed," see Measure 3.5 and 3.6 Defining Successfully Housed.

How CoCs can assist

CoCs can connect as many MCP members experiencing homelessness as possible to the community's CE, as well as referred to and connected to ECM, housing-related CS, and other resources and services that help people find and access stable housing. They can also share with the MCPs the lack of affordable housing in the area and discuss ways to leverage MCP funding to increase housing availability.

Metric 3.6: MCP Members who remained successfully housed

MCPs had to report on the percentage of their members experiencing homelessness who were successfully housed between Jan. 1-Apr. 30, 2022 who remained housed through December 31, 2022. For Measurement Period 2, DHCS wants to know how many of those same people are still housed as of October 31, 2023. They also want to know how many members who were housed in the latter eight months of 2022 are still housed as of October 31, 2023.

Information required:

- The percentage of MCP members experiencing homelessness who were successfully housed during the first four months of 2022 who remained housed through October 31, 2023.
- The percentage of their members experiencing homelessness who were successfully housed from May 1-Dec. 31, 2022 who remained housed through October 31, 2023.

MCPs must also describe the methods they used to keep members housed, including rental subsidies, direct financial assistance, housing matching, and other methods.

To meet the performance measurement

This is a Pay for Performance Metric. MCPs must report at least 85% for full points; partial points will be awarded for significant achievement that is less than 85%.

How CoCs can assist

Provide insight to MCPs on the strategies and supports most likely to help recently homeless individuals and families sustain their housing. CoCs can also provide MCPs information on prevention resources that exist in the community for any recently housed members who are at risk of experiencing homelessness again. They can also share with MCPs the lack of affordable housing in the area and discuss ways to leverage MCP funding to increase housing availability.

Successfully Housed

For example, if the MCP reported for Measurement Period 1 that 7% of their members who experienced homelessness between May 1, 2022 and December 31, 2022 were successfully housed during that time, to receive full points for Measurement Period 2, they will have to report that at least 32% of their members who experienced homelessness between January 1, 2023 and October 31, 2023 were successfully housed during that time.

Maximizing CalAIM's Enhanced Care Management Benefit and Community Supports Services

Homebase
with the support of the California Health Care Foundation

California's new Medi-Cal Initiative, CalAIM (California Advancing and Innovating Medi-Cal) includes two programs that provide coordination and/or housing-related services for its members, including those experiencing homelessness: **Enhanced Care Management (ECM)** and **Community Supports (CS)**. Through the Housing and Homelessness Incentive Program (HHIP), the state Department of Health Care Services has incentivized Medi-Cal managed care plans (MCPs) to connect their eligible members experiencing homelessness to ECM and CS services. In partnership with their local MCPs, CoCs should discuss ways to ensure people they're serving are referred and receiving these vital benefits and services.

The CS services offered in each community through MCPs vary, as do the referral processes for both ECM and CS. CoCs should work directly with their local MCPs to coordinate efforts to refer and connect people to these resources by simplifying and streamlining the referral processes.

This document provides basic information about ECM and CS and offers tools to help CoCs track the resources available and relevant referral processes for the MCPs in their communities.

Basics of ECM and Community Supports

Enhanced Care Management (ECM)

Many Medi-Cal members need the services of multiple social services systems, in addition to the health care system. Enhanced Care Management (ECM) is a Medi-Cal benefit that all Medi-Cal managed care plans (MCPs) are required to provide to eligible members. ECM offers intensive care coordination and services across the multiple systems. The core services offered through ECM are:

1. Enhanced coordination of care
2. Coordination of and referral to community and social support services
3. Outreach and engagement
4. Comprehensive assessment and care management plan
5. Health promotion
6. Comprehensive transitional care
7. Member and family supports

ECM providers help people set clear goals, make sure they receive the full array of benefits they're eligible for to meet those goals, and coordinate across systems to help members achieve their goals. MCPs are required to meet members enrolled in ECM where they are, instead of just at the doctor's office. ECM providers can offer services to members at an emergency shelter, on the street, or at home. Each person enrolled in ECM has a central case manager who coordinates their care and services across all the systems, making it easier "to get the right care at the right time."

Community Supports (CS)

Community Supports are new services that Medi-Cal managed care plans (MCPs) can add to their package of services. They are intended for Medi-Cal members with complex health needs who also have unmet social needs (e.g., due to food insecurity, homelessness, or systemic racism). There are 14 total Community Supports, including housing-related ones. MCPs can decide which Community Supports to offer. The CS services available to eligible members vary across the state and even within a county if multiple MCPs operate there. The six CS services most directly relevant to housing, which many MCPs across the state offer, are:

- Housing Transition Navigation Services
- Housing Deposits
- Housing Tenancy and Sustaining Services
- Short-Term Post-Hospitalization Housing
- Recuperative Care (Medical Respite)
- Day Habilitation Programs

MCPs contract with local providers to provide CS services to members who are referred and approved to receive them. Local housing and homeless service providers who already provide the services covered under CS should consider becoming contracted providers with their local MCPs so they can be reimbursed for providing those services to people experiencing homelessness who are MCP members.

Connecting People Experiencing Homelessness to ECM and CS Services

MCPs are incentivized in various ways, including through HHIP, to connect their members experiencing homelessness to ECM and CS services. CoCs can be critical partners in identifying eligible members and helping to refer them to ECM and whatever available CS services they need and are eligible for. By utilizing these health system resources, CoCs can preserve their own resources to help people who are not enrolled in Medi-Cal or are ineligible for ECM or CS services.

Medi-Cal members who are eligible for ECM and CS services can be referred by anyone (themselves, community members/family members, providers). For people enrolled in ECM, their ECM provider can and should support them to identify the CS services they need and refer them to those.

To be referred for ECM or any Community Supports, a person must be enrolled in Medi-Cal and have selected an MCP. CoCs should support people experiencing homelessness not yet enrolled in Medi-Cal to explore their eligibility, enroll if eligible, and select their MCP. The offices that handle Medi-Cal enrollment in each county in California are listed here.

Once a person is approved and enrolled in ECM or CS, they will be matched with a provider.

- MCPs contract with different providers for ECM and CS.
- People who are enrolled in both ECM and CS may not have the same provider for both (or the same provider for different Community Supports if they are receiving more than one service).
- If a person is enrolled in ECM, their ECM provider can and should assess and refer them to appropriate CS services.

The following pages include additional eligibility information for both ECM and CS, as well as guidance and tools to help ensure as many eligible people as possible are aware of, referred to, and connected to ECM and the CS services they need.

Enhanced Care Management (ECM)

Eligibility

To be eligible for ECM, a person must be:

- Enrolled in Medi-Cal
- Connected to a Medi-Cal managed care plan, and
- Part of one of the following populations of focus
  - **Individuals and families experiencing homelessness <u>and</u>** the individual has at least one complex physical, behavioral, or developmental health need with inability to successfully self-manage for whom coordination of services would likely result in improved health outcomes AND/OR decreased utilization of high-cost services.
  - Individuals at risk for avoidable hospital or Emergency Department utilization
  - Individuals with serious mental health and/or substance use disorder (SUD) needs
  - Individuals transitioning from incarceration
  - Adults living in the community and at risk for Long Term Care (LTC) institutionalization
  - Adult nursing facility residents transitioning to the community
  - Children and youth enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with additional needs beyond the CSS condition
  - Children and youth involved in Child Welfare
  - Individuals with Intellectual or Developmental Disabilities (I/DD)
  - Pregnant and postpartum individuals

People who are part of a population of focus but not yet enrolled in Medi-Cal or connected to a plan should be supported to enroll in Medi-Cal and select their MCP. The offices that handle Medi-Cal enrollment for each county in California are listed here.

Referrals

Most, if not all, MCPs will accept ECM referrals from anyone: members themselves; providers or case workers; or family members, friends, or other support people.

Every MCP has its own referral forms and processes for ECM. In some communities, all the Medi-Cal MCPs have coordinated to agree on a consistent ECM referral form. CoCs with multiple MCPs operating in their coverage area should work together with the MCPs to establish a jointly accepted ECM referral form (and needed documentation) and a consistent referral process. The process should include what happens after referrals are made, a timeframe and process for MCPs to update the CoC or CoC providers when members are enrolled in ECM, information about who their ECM provider is in the community, and a consistent way for ECM providers to connect with CoC providers working with newly enrolled members.

Most MCPs accept ECM referral forms and supporting documentation through submission to an online portal, secure email, fax, or a combination of those three. Most, if not all, also allow people to call a designated telephone number to begin a referral. The specific websites, email addresses, fax and phone numbers will vary by MCP and by county. At the end of this document is a template CoCs can use to collect and compile the referral information specific to the MCPs in their community.

Examples of Complex Physical, Behavioral, and Developmental Health Needs

Physical	Behavioral	Developmental
• Asthma • Chronic kidney disease • Chronic liver disease • Chronic obstructive pulmonary disease (COPD) • Congestive heart failure • Coronary artery disease • Dementia requiring assistance with activities of daily living • Diabetes (insulin-dependent) poorly controlled • History of stroke or heart attack • Hypertension • Traumatic brain injury • Other*	• Bipolar disorder • Major depressive disorder • Psychotic disorders, including schizophrenia • Substance use disorder • Other*	• Intellectual or developmental disability (I/DD) • Other*

* There may be qualifying conditions not listed in this table

Community Supports (CS)

Eligibility and Availability

Like with ECM, Community Supports are only available to people who are already enrolled in Medi-Cal and connected to a Medi-Cal MCP.

Each Community Support has different eligibility criteria. Details about the service definitions and eligibility for each of the 14 Community Supports can be found in the DHCS Community Supports Policy Guide.

CoCs should work with their local MCPs to understand what Community Supports they offer, which they intend to offer in the future, and to present information about the most relevant CS services for people experiencing homelessness in their communities to CoC providers who can help identify and refer people who may be eligible.

The example template below is intended to help CoCs and their partner MCPs summarize the CS services available to people experiencing homelessness in their communities.

To create your county's Community Supports summary table, fill in a column for each MCP operating in your area, using similar color coding to indicate which Community Supports each MCP currently offers, and which they intend to offer in the future, noting the date each will be available. If you are not already in contact with the MCPs in your area, you can find them on the DHCS website.

Referrals

Like with ECM, MCPs will accept CS service referrals from anyone: members themselves; providers (including ECM and CS providers), case workers; or family members, friends, or other support people.

Because each MCP selects the CS services they want to offer, each MCP has its own referral or authorization forms and processes for CS. Some have separate referral or authorizations forms for each Community Support, although the referral process should be the same regardless of which CS is being requested.

CoCs and their local MCPs should work together to simplify and streamline the forms and processes for people experiencing homelessness as much as possible, including supporting documentation required. As with ECM, the process should include what happens after referrals are made, including a timeframe and process for MCPs to update the CoC or CoC providers when members are authorized to receive a CS, who their CS provider is, and a consistent way for CS providers to connect with CoC providers working with the person who's been enrolled.

As with ECM, most MCPs accept referral or authorization forms and supporting documentation through submission to an online portal, secure email, fax, or a combination. The specific websites, email addresses, fax and phone numbers will vary by MCP and by county. At the end of this document is a template CoCs can use to collect and compile the referral information specific to the MCPs in their community.

Blue = currently available **Purple** = upcoming

Community Supports	[MCP1]	[MCP2]	[MCP3]
1. Housing transition navigation services			
2. Housing tenancy and sustaining services			
3. Housing deposits (Note: With some exceptions, most people must be receiving housing navigation through the MCP to get housing deposits and may need to meet other criteria, such as being placed high on the priority list through the CoC's CE System).			
4. Short-term post hospitalization temporary housing		1/24	1/24
5. Recuperative care/medical respite	1/24	1/24	1/24
6. Respite services		7/23	1/24
7. Day habilitation programs		7/23	1/24
8. Nursing facility transition to assisted living			1/24
9. Community transitions/nursing facility transitions to home			1/24
10. Personal care and homemaker services		7/23	1/24
11. Environmental accessibility adaptations			1/24
12. Medically tailored meals			1/24
13. Sobering centers	1/24	1/24	1/24
14. Asthma Remediation	1/24	1/22	1/24

Recommendations for CoCs to Discuss with their Partner MCPs to Maximize Utilization of ECM and CS

- How to streamline the forms (e.g., make one single form that can be used for all MCPs), required documentation and processes for ECM and CS referrals and clearly outline the steps of the process, timeframes, and information and documentation needed.
- Protocols that apply after referrals are submitted to:
  - Update the CoC (or provider who submitted the referral) on referral status and any missing documentation or issues with the form or authorization request;
  - Confirm enrollment/approval;
  - Provide name and contact information of ECM or CS provider and/or ensure proactive outreach by that provider to the CoC.
- Ensure the success of ECM and CS providers assigned to members experiencing homelessness by:
  - Matching members with providers who have experience working with people experiencing homelessness;
  - Minimizing the number of providers each person is connected to (especially if multiple CS services are involved);
  - Identifying CoC providers to become contracted CS providers.
- The most needed CS services among people experiencing homelessness and how the CoC can help train providers who engage with people most in need of those services to help facilitate successful referrals.

Template for Compiling ECM and CS Referral Information

ENHANCED CARE MANAGEMENT (ECM) REFERRALS IN [COUNTY]

Managed Care Plan	Referral Process
[Name of MCP]	Complete [link to shared ECM referral form, if applicable, and/or MCP's own referral form] ECM Referral Form Gather necessary supporting documentation (see table below) Submit completed ECM Form and supporting documentation via: • [insert link to online portal if applicable] • [provide email address and any additional details, such as what subject line should be and whether a secure email program is required] • [provide fax number if relevant] • [insert any other submission option] OR, call [insert relevant phone number] and mention wanting to make an ECM referral.

Documentation needed to support ECM Referral Form

The following are examples of documentation MCPs might expect or require. CoCs should adjust this as needed after consulting with their local MCPs.

- Documentation of homelessness by service provider, primary care physician (PCP), specialist, or outreach provider
- Eviction Notices
- Documentation of entries / exits from shelters
- Documentation / office visit note with diagnosis or identification of at least one complex physical, behavioral, or developmental health need
- Medication / treatment orders
- Financial statements

CS REFERRALS/AUTHORIZATION REQUESTS IN [COUNTY]

Managed Care Plan	Referral Process
[Name of MCP]	Complete [link to MCP's referral or authorization form] Community Supports Referral/Authorization *Note: If the MCP uses different forms for each Community Support, be sure to list each one separately.* Gather necessary supporting documentation (see table below) Submit completed Referral/Authorization Form and supporting documentation via: • [insert link to online portal if applicable] • [provide email address and any additional details, such as what subject line should be and whether a secure email program is required] • [provide fax number if relevant] • [insert any other submission option] OR, call [insert relevant phone number] and mention wanting to make a Community Supports referral.

Documentation Needed to Support CS Referral Forms / Authorization Requests

The following are examples of supporting documentation that may be expected or required for each housing-related CS. CoCs are encouraged to work with their local MCPs to identify the specific supporting documentation that is most relevant and practical for the CS services most needed by people experiencing homelessness in their communities and adjust this accordingly.

Housing transition navigation services	Documentation of homelessness or risk of homelessness by service provider, Primary Care Physician (PCP), specialist, or outreach provider; documentation of entries/exits from shelters; notices from current landlord if applicable; financial statements
Housing tenancy and sustaining services	Housing support plan (aka housing plan[1]) created by MCP; lease agreement
Housing deposits	Housing support plan; lease agreement; utility bill/deposit agreement; financial statements
Short-term post hospitalization temporary housing	Emergency department or inpatient discharge planning paperwork; documentation of homelessness by service provider, PCP, specialist, or outreach provider; documentation of member participation in housing transition navigation services
Recuperative care (medical respite)	Emergency department, inpatient, or skilled nursing discharge paperwork; documentation of homelessness by service providers, PCPs, specialists, or outreach providers; documentation of entries/exits from shelters; documentation from any support agency indicating services/ supports member needs; documentation/office visit notes with diagnosis and identification of frailty; assessment determining limitations in activities of daily living (ADLs); medication/ treatment orders
Day habilitation programs	Documentation of housing status by service providers, PCP, specialist or outreach providers; documentation of participation in housing transition/navigation or housing tenancy and sustaining services

[1] If you have already created a housing plan for your client, we recommend sending the plan with the referral to the MCP. This will help MCPs to understand the client's needs and can be used as a basis for an MCP-created housing plan, if appropriate.

CalAIM's Community Supports: Housing-Related Services

Homebase
with the support of the California Health Care Foundation

Created through the new CalAIM initiative, Community Supports are medically appropriate and cost-effective alternatives to services covered under California's traditional Medi-Cal program. The services are designed to help Medi-Cal members with complex health conditions meet critical social needs, including housing-related needs. Medi-Cal managed care plans (MCPs) can choose to offer 14 Community Supports; at least 4 of the Community Supports offer housing-related services to eligible people experiencing or at risk of homelessness.

Many of the services offered under different Community Supports are services that homeless providers already offer people experiencing homelessness. Thus, the option to get paid for CalAIM Community Supports through contracts with local Medi-Cal MCPs provides important opportunities for homeless systems of care to:

- Expand the type of work providers can get compensated to do in their communities;
- Access new funding streams (via Medi-Cal) to pay for services already provided;
- Increase the number of organizations able to provide Community Supports;
- Enhance the types of services offered to people experiencing homelessness; and
- Provide coordinated care for vulnerable populations.

Across all Community Supports, Medi-Cal:

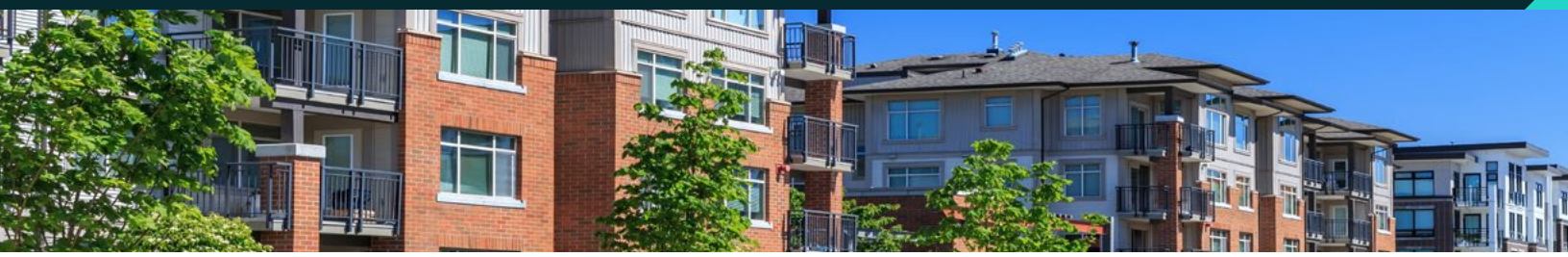
- Requires that Community Supports not supplant services received by the Medi-Cal member through other State, local, or federally-funded programs;
- Encourages all providers to use best practices when engaging with members who are experiencing homelessness and who have complex health, disability, and/or behavioral health conditions. These best practices include Housing First, harm reduction, progressive engagement, motivational interviewing, and trauma-informed care; and
- Allows a range of organizations and agencies to serve as Community Supports providers (so long as they are certified with their local Medi-Cal MCPs).

Community Supports are a unique opportunity to leverage Medi-Cal resources to provide comprehensive services to people experiencing homelessness without taxing under-resourced homeless systems of care.

The list of CalAIM's housing-related Community Supports includes:

- *Housing Transition/Navigation Services*;
- *Housing Tenancy & Sustaining Services*;
- *Housing Deposits*; and
- *Short-Term Post Hospitalization Housing*.

The following pages provide an overview and additional details about each of these four housing-related Community Supports.



CalAIM Community Supports: Housing Transition/Navigation Services[1]

Overview

Housing Transition/Navigation Services are intended to help eligible Medi-Cal members navigate the process of searching for and obtaining housing. **Many of the services offered under Housing Transition/Navigation are services that homeless service providers already offer people experiencing homelessness.**

There are many services that a Medi-Cal member can receive under Housing Transition/Navigation. The specific services offered should be based on each individual's assessment and documented in an individualized housing support plan.[2] Housing Transition/Navigation providers can:

- Conduct screening and housing assessments to identify the member's preferences and barriers that enable or prevent them from accessing and maintaining stable housing.
- Develop an individualized housing support plan that addresses barriers, develops goals and approaches to each housing issue, and identifies additional providers and services needed to meet the identified goals.
- Search for and share housing options with the member.
- Assist in obtaining housing, including activities like completing housing applications and accessing required documentation (e.g., Social Security card, birth certificate, prior rental history).
- Assist with benefits advocacy, including getting identification and documentation for SSI eligibility and supporting the SSI application process or other public benefits.
- Identify and secure resources for members to access subsidized rent programs (such as HUD's Housing Choice Voucher Program (Section 8), or state and local rental assistance).
- Identify and secure resources to cover housing expenses like security deposits, moving costs, adaptive aids, environmental modifications, moving costs, and other one-time expenses.[3]
- Assist with requests for reasonable accommodation.[4]
- Identify, coordinate, secure and fund environmental modifications for necessary accessibility accommodations.
- Educate and engage the landlord.
- Ensure the living environment is safe and move-in ready.
- Communicate with the landlord and advocate on behalf of the member.
- Identify, coordinate, secure, or fund non-emergency, non-medical transportation to ensure reasonable accommodations and access to housing prior to and on move-in day.
- Help arrange and support the move.
- Establish contacts and procedures to retain housing, including development of a housing support crisis plan that includes prevention and early intervention services that can be deployed if/when housing is jeopardized.[5]

Housing Transition/Navigation services may need to be coordinated with other entities – such as legal aid programs, mental health and social services departments, County and City Housing Authorities, etc. – to ensure that members have access to the comprehensive supports required to access and retain stable housing. Providers may need to coordinate closely with the local Coordinated Entry System, homeless providers, public housing authorities, and others who fund housing assistance, particularly on behalf of members who need rental subsidy support to obtain permanent housing.

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[1] Information in this fact sheet is summarized from the Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide, Department of Health Care Services, January 2023.

[2] Services do not include the provision of room and board or payment of rental costs.

[3] Note that the payment of housing deposits and/or move-in expenses is a separate Community Support; see the *Housing Deposits* overview for more information.

[4] This relates to expenses incurred by the housing navigator supporting the individual moving into the home.

[5] Note that the services associated with the crisis plan are a separate Community Support; see the *Housing Tenancy and Sustaining Services* overview for more information.

Eligibility for Housing Transition/Navigation

Medi-Cal members who are eligible[6] for Housing Transition Navigation services include:

- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system;
- Individuals who meet the HUD definition of "homeless" (including those exiting an institution, with no limit on the number of days in the institution[7]) ***and*** who receive enhanced care management (ECM) or who 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.
- Individuals who meet the HUD definition of "at risk of homelessness" (including children who do not qualify as homeless under the HUD definition but do qualify under other programs[8]) ***and*** also meet at least one of the following criteria:
  - They have one or more serious chronic conditions;
  - They have a serious mental illness;
  - They are at risk of institutionalization or overdose or are requiring residential services due to a substance use disorder or serious emotional disturbance (children and adolescents);
  - They receive Enhanced Care Management (ECM); or
  - They are a transitional age youth (TAY) with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or have been victims of trafficking or domestic violence.

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.**
- Frequency: N/A
- Other: N/A

Who can Provide Housing Transition/Navigation Services

Providers must have experience and expertise providing Housing Transition/ Navigation services in a culturally and linguistically appropriate manner. A range of organizations are eligible to serve as Housing Transition/ Navigation providers, so long as the agencies and individual providers have demonstrated experience providing housing-related services and supports and are certified as Community Supports providers through their local Medi-Cal MCPs.

[6] MCPs may accept an attestation of the need for housing to satisfy any documentation requirements regarding the member's housing status.

[7] For this Community Support, "institution" includes: hospitals, correctional facilities, mental health or substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease, and State Hospitals.

[8] A child and youth may also qualify as homeless under the following programs: the Runaway & Homeless Youth Act, the Head Start Act, the Violence Against Women Act of 1994, the Public Health Service Act, the Food & Nutrition Act of 2008, the Child Nutrition Act of 1966, and the McKinney-Vento Homeless Assistance Act.

CalAIM Community Supports: Housing Tenancy & Sustaining Services[9]

Overview

Housing Tenancy & Sustaining Services (TSS) are services intended to help eligible Medi-Cal members maintain safe and stable tenancy once they have housing. **Many of the services offered under TSS are services that homeless service providers already offer people experiencing homelessness.**

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.

There are a number of services that can be provided under Tenancy & Sustaining Services:

- Early identification of and intervention around behaviors that may jeopardize housing, such as late rental payment, hoarding, substance use, and other lease violations.
- Education and training on the role, rights, and responsibilities of the tenant and landlord.
- Coaching to help Medi-Cal members develop and maintain key relationships with landlords/property managers.
- Coordination with a landlord and case manager to address identified issues that could impact housing stability.
- Assistance to resolve disputes with landlords and/or neighbors to reduce the risk of eviction or other adverse actions; might include development of a repayment plan or identification of funding to help with back rent or payment for damage to the unit.
- Advocacy and linkage with community resources to prevent eviction when housing is or may potentially become jeopardized.
- Assistance with benefits advocacy, including getting identification and documentation for SSI eligibility and supporting the SSI application process or other public benefits.
- Assistance with the annual housing recertification process.
- Coordination with the tenant to review, update and modify their housing support and crisis plan on a regular basis to reflect current needs and address existing or recurring housing retention barriers.
- Ongoing assistance with lease compliance, including ongoing support with activities related to household management.[10]
- 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 (e.g., assistance with reasonable accommodation requests that were not initially required upon move-in).
- Assistance with independent living, life skills, and training on budgets, including financial literacy and connection to community resources.

Not every Medi-Cal member will be eligible for the full set of services covered by TSS. Each set of services will be customized based on the unique needs of each member based on the individualized housing support plan created through Housing Transition/Navigation Services.[11,12]

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[9] Information in this fact sheet is summarized from the Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide, Department of Health Care Services, January 2023.

[10] Does not include help with housing quality inspections.

[11] Services do not include the provision of room and board or payment of rental costs.

[12] See the *Housing Transition/Navigation Services* overview for more information.

Eligibility for TSS

Medi-Cal members who are eligible[13] for TSS include:

- Any Medi-Cal member who received Housing Transition/ Navigation Services.
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system;
- Individuals who meet the HUD definition of "homeless" (including those exiting an institution, with no limit on the number of days in the institution[14]) ***and*** who receive enhanced care management (ECM) or who 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.
- Individuals who meet the HUD definition of "at risk of homelessness" (including children who do not qualify as homeless under the HUD definition but do qualify under other programs[15]) ***and*** also meet at least one of the following criteria:
  - They have one or more serious chronic conditions;
  - They have a serious mental illness;
  - They are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder of have a serious emotional disturbance (children and adolescents);
  - They receive Enhanced Care Management (ECM); or
  - They are a transitional age youth (TAY) with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/ or who have been victims of trafficking or domestic violence.

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.
- Other: N/A

Who can Provide TSS

Providers must have experience and expertise providing TSS in a culturally and linguistically appropriate manner. Organizations and agencies providing services to individuals experiencing homelessness are eligible providers, so long as they are certified as Community Supports providers through their local Medi-Cal MCPs. The Department of Health Care Services requires that Medi-Cal MCPs coordinate with homeless service systems to provide TSS.

[13] MCPs may accept an attestation of the need for housing to satisfy any documentation requirements regarding the member's housing status.

[14] For this Community Support, institution includes: hospitals, correctional facilities, mental health or substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease, and State Hospitals.

[15] A child and youth may also qualify as homeless under the following programs: the Runaway and Homeless Youth Act, the Head Start Act, the Violence Against Women Act of 1994, the Public Health Service Act, the Food and Nutrition Act of 2008, the Child Nutrition Act of 1966, and the McKinney-Vento Homeless Assistance Act.

CalAIM Community Supports: Housing Deposits[16]

Overview

Housing Deposits are intended to help identify, coordinate, secure, or fund one-time services or modifications necessary to enable a person to establish a basic household. **Many things covered by Housing Deposits are among those that homeless service providers already help people experiencing homelessness with**, and include the following:

- Security deposits required to obtain a lease;
- Set-up fees or deposits for utilities or service access and utility arrears;
- First month coverage of utilities (including phone, gas, electricity, heating, water);
- First and last months' rent if required by a landlord for occupancy;
- Services necessary for a person's health and safety, such as pest eradication and one-time pre-move-in cleaning; and
- Goods necessary to ensure access and safety for a person upon move-in, such as an air conditioner or heater and other medically-necessary adaptive aids and services designed to preserve a person's health and safety in the home (e.g., hospital beds, Hoyer lifts, air filters, specialized cleaning or pest control supplies).

Individuals may only require a subset of the services listed above. Services provided should be based on an assessment of each individual's needs and documented in their housing support plan.[17]

Housing Deposits may not be used for room and board or payment of ongoing rental costs (beyond the first and last months' coverage, as listed above).

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[16] Information in this fact sheet is summarized from the Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide, Department of Health Care Services, January 2023.

[17] See the *Housing Transition/Navigation Services* overview for more information about housing support plans.

Eligibility for Housing Deposits

Medi-Cal members who are eligible[18] for Housing Deposits include:

- Anyone who received the Housing Transition/Navigation Services Community Support;
- Individuals who are prioritized for a permanent supportive housing unit or rental subsidy resource through the local homeless Coordinated Entry System or similar system;
- Individuals who meet the HUD definition of "homeless" (including those exiting an institution, with no limit on the number of days in the institution[19]) ***and*** who receive enhanced care management (ECM) or who 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: N/A
- Frequency: **Housing Deposits are only available once in a person's lifetime** and can only be **approved one additional time with documentation** about what conditions have changed to demonstrate why providing Housing Deposits would be more successful the second time.
- Other: The services must be **identified as reasonable and necessary in the person's individualized housing support plan** and are only available when the person is unable to meet the expense. Other: People **must also receive Housing Transition/Navigation services** (at a minimum, the associated tenant screening, housing assessment, and individualized housing support plan) in conjunction with Housing Deposits.[20]

Who can Provide Housing Deposits

Providers must have experience and expertise providing Housing Deposit services in a culturally and linguistically appropriate manner. A Medi-Cal managed care plan (MCP) case manager, care coordinator, or housing navigator may coordinate and pay for Housing Deposit services directly or subcontract the services.

Organizations and agencies providing services to individuals experiencing homelessness may be eligible providers, so long as the agencies and individual providers have demonstrated experience providing these services and are certified as Community Supports providers through their local Medi-Cal MCPs.

[18] MCPs may accept an attestation of the need for housing to satisfy any documentation requirements regarding the member's housing status.

[19] For this Community Support, institution includes: hospitals, correctional facilities, mental health or substance use disorder residential treatment facility, recovery residences, Institution for Mental Disease, and State Hospitals.

[20] See the *Housing Transition/Navigation* overview for more information.

CalAIM Community Supports: Short-Term Post-Hospitalization Housing[21]

Overview

Short-Term Post-Hospitalization Housing is temporary housing for individuals who have high medical or behavioral health needs, need the opportunity to continue their recovery from medical/psychiatric/substance use disorder(s), and have recently exited from the hospital or other institutional setting (see list of qualifying institutions in Eligibility section). **Many homeless service agencies are uniquely positioned to become contracted providers of Short-Term Post Hospitalization Housing, as many of them already provide these supportive services along with housing.**

Short-Term Post-Hospitalization Housing must give the individual the opportunity to:

- Recuperate and recover (i.e., gain or regain the ability to perform activities of daily living);
- Receive necessary medical/psychiatric/substance use disorder care and case management; and
- Become connected to other housing and Community supports such as Housing Transition/Navigation.

The setting for Short-Term Post-Hospitalization Housing may be individual or shared interim housing, as long as residents receive the services described.

Medi-Cal members must be offered Housing Transition/Navigation supports during their stay in Short-Term Post-Hospitalization Housing to prepare them to transition to more permanent housing. Housing Transition/Navigation covers the development of a housing assessment and individualized housing support plan.[22]

Eligibility for Short-Term Post-Hospitalization Housing

Medi-Cal members who are eligible[23] for Short-Term Post-Hospitalization Housing include:

- Individuals exiting recuperative care;
- Individuals exiting an inpatient hospital stay (either acute or psychiatric or Chemical Dependency and Recovery hospital), residential substance use disorder treatment or recovery facility, residential mental health treatment facility, correctional facility, or nursing facility ***and*** who meet any of the following criteria:
  - Individuals who meet the HUD definition of "homeless" (including those exiting an institution, with no limit on the number of days in the institution[24]) and who receive enhanced care management (ECM) or who have one or more serious chronic conditions and/or a serious mental illness and/or are at risk of institutionalization or who may require residential services as a result of a substance use disorder.
  - Individuals who meet the HUD definition of "at risk of homelessness"[25] (including children who do not qualify as homeless under the HUD definition but do qualify under other programs[26]) who have significant barriers to housing stability AND meet at least one of the following:
    - Have one or more serious chronic conditions;
    - Have a serious mental illness;
    - Are at risk of institutionalization or overdose or are requiring residential services because of a substance use disorder or have a serious emotional disturbance (children and adolescents);
    - Are receiving Enhanced Care Management (ECM); or
    - Are a transitional age youth (TAY) with significant barriers to housing stability, such as one or more convictions, a history of foster care, involvement

[21] Information in this fact sheet is summarized from the Medi-Cal Community Supports, or In Lieu of Services (ILOS), Policy Guide, Department of Health Care Services, January 2023.

[22] See the *Housing Transition/Navigation* overview for more information about the services included.

[23] MCPs may accept an attestation of the need for housing to satisfy any documentation requirements regarding the member's housing status.

[24] For this Community Support, institution includes: hospitals, correctional facilities, mental health or substance use disorder residential treatment facility, recovery residences, Institutions for Mental Disease, and State Hospitals. If exiting an institution, individuals are considered homeless if they were homeless immediately prior to entering that institutional stay, regardless of the length of institutionalization.

[25] The timeframe for an individual or family who will imminently lose housing is extended from (14) days for individuals considered homeless to thirty (30) days.

[26] A child and youth may also qualify as homeless under the following programs: the Runaway and Homeless Youth Act, the Head Start Act, the Violence Against Women Act of 1994, the Public Health Service Act, the Food and Nutrition Act of 2008, the Child Nutrition Act of 1966, and the McKinney-Vento Homeless Assistance Act.

with the juvenile justice or criminal justice system, and/or have a serious mental illness and/or a child or adolescent with serious emotional disturbance and/or who have been victims of trafficking or domestic violence.

In addition to meeting one of these criteria, at minimum, eligible individuals must have medical or behavioral health needs such that experiencing homelessness upon discharge from one of these settings would likely result in in the person being hospitalized, re-hospitalized, or re-admitted to an institutional setting.

Restrictions/Limitations

- Duration: Short-Term Post-Hospitalization Housing services **cannot exceed a duration of six (6) months.**[27]
- Frequency: Short-Term Post-Hospitalization Housing services are available **once in an individual's lifetime.**
- Other: The service is only available **if the enrollee is unable to meet such an expense** on their own.

Who can provide Short-Term Post Hospitalization Housing

Providers must have experience and expertise with providing services such as medical/psychiatric/substance use disorder care, case management, and housing-related services and supports.

A range of organizations and agencies are eligible to serve as Short-Term Post Hospitalization Housing providers so long as they can provide the unique services to meet the needs of eligible individuals. Examples include:

- Interim housing facilities with additional on-site support;
- Shelter beds with additional on-site support;
- Converted homes with additional on-site support;
- County directly operated or contracted recuperative care facilities;
- Supportive housing providers;
- County agencies;
- Public hospital systems;
- Social service agencies; and/or
- Providers of services for individuals experiencing homelessness.

[27] Services may be authorized for a shorter period based on individual needs.

Sample Bi-lateral Data Sharing Agreement Between a Continuum of Care and Managed Care Plan

Homebase
with the support of the California Health Care Foundation

This is a sample bi-lateral data sharing agreement (DSA) that is meant to help cross-sector partners identify the common components of a DSA between Continuum of Care (CoC) agencies responsible for HMIS data and Medi-Cal managed care plans (MCPs). The content in this sample is provided for informational purposes only and does not constitute legal advice. Homebase does not enter into attorney-client relationships nor dispense legal advice.

We do not recommend adopting this sample wholesale. To enter into a DSA requires review by legal experts in privacy and security. If you do not have the resources to hire legal specialists in privacy, consult with your County Counsel. Note, however, that County Counsel may not have the expertise necessary to draft a cross-sector DSA without the advice of experts in data privacy and security.

Under this sample agreement, the intention is to have Medi-Cal MCPs receive Personally Identifiable Information (PII) from the HMIS Lead. The data from HMIS will allow the MCPs to identify which of their members are known by the CoC to be experiencing homelessness. In exchange, the CoC will receive information about which individuals in HMIS are MCP members, what plans they are enrolled in, and whether they are receiving housing-related services through the MCP, especially Enhanced Care Management (ECM) or Community Supports (CS).

The sample agreement can be customized to a specific community. Throughout the document, there are *plain-language explanations and directions in italicized red text* to guide you through the sections of the DSA.

Homebase would like to thank Benefits Data Trust (BDT) for allowing us to use their shell Data Sharing Agreement, which can be found in "Bolstering Benefits Access: Introducing Benefits Data Trust's New Data Sharing Playbook," as a model for this sample CoC-MCP agreement.

Continuum of Care and Medi-Cal Managed Care Plan Sample Bi-lateral Data Sharing Agreement (DSA)

Article I: Business Justification and Scope of Services

PRIMARY AGENCY

Entity:	**Managed Care Plan**
Agency Data Steward:	**Jane Steward**
Steward's Title:	**Data Steward**
Address:	**123 Work Address, Data City, CA 54321**
Phone Number:	**555-555-5555**
Email:	**JSteward@mcp.com**

SECONDARY AGENCY

Entity:	**CoC HMIS Lead**
Secondary Agency Data Steward:	**Freddie Hamis**
Steward's Title:	**HMIS Administrator**
Address:	**10101 HMIS Lane, CoC City, CA 54321**
Phone Number:	**555-555-5556**
Email:	**Freddie@hmislead.org**

BUSINESS JUSTIFICATION

Managed Care Plan adheres to the principle of least privilege, meaning that recipients of data and information should receive no more information than is absolutely necessary to complete an assigned project, job, task, or responsibility.

The purpose of this DSA is to create an agreement between **Managed Care Plan** and **CoC HMIS Lead** to 1. identify Medi-Cal MCP members who are experiencing homelessness so that **Managed Care Plan** can conduct outreach and provide housing and supportive services to their members who are experiencing homelessness in **Collab County** and 2. the CoC can determine whether participants in HMIS have Medi-Cal or are receiving other housing-related services through Medi-Cal.

To this end, this DSA provides conditions and safeguards for a limited exchange of Personally Identifiable Information (PII) between the parties while protecting the confidentiality of **Managed Care Plan** and **Collab County CoC** members, applicants, and participants, consistent with requirements of federal and state law.

Insert specific legal analysis of applicable data sharing and confidentiality law here. For more on the legal

analysis related to sharing specific program data, see Section 3: The Building Blocks of Data Sharing in Data Sharing to Build Effective and Efficient Benefits Systems.

SCOPE OF SERVICES:

***Tip:** It may be helpful to specify in the data sharing agreement or an accompanying document how the data sharing process will be initiated. Are there processes for requesting data reports from agency systems? If yes, what are they?*

Managed Care Plan agrees to:

- Utilize the data provided by **CoC HMIS Lead** only for the purpose outlined in the Business Justification section above.
- Match the data provided by **CoC HMIS Lead** against current databases of **Managed Care Plan** members to identify those individuals who have been identified through the **Collab County CoC**'s Coordinated Entry System as experiencing homelessness as outlined in Article III, Section 1.
- Receive data from **Freddie Hamis** through a Secure File Transfer Protocol (SFTP) and limit the number of employees who will collect and analyze the data to those absolutely necessary to perform the data matches.
- After the data match is complete, destroy all data where no match was found in **Managed Care Plan's** database.
- Within five (5) business days of the execution of this agreement, provide to **Freddie Hamis** an estimate of the time required to fulfill the data match request.
- Provide to the **Freddie Hamis** a list of the matches, with added information about each **Managed Care Plan** member, including: Medi-Cal number, whether they are receiving Enhanced Care Management (ECM), whether they are receiving any Community Supports, and if so, which Community Supports they are receiving.

CoC HMIS Lead agrees to:

- Provide the PII data outlined in Article III to **Managed Care Plan** within **14 days** of the signing of this agreement. *14 days is used here as an example, not a recommendation.*
- *Add other terms and conditions to articulate and facilitate data sharing.*

Article II: Term Agreement

The terms and conditions contained herein shall be binding once this Agreement is signed by all parties.

1. **CoC HMIS Lead** does not guarantee the completeness or accuracy of the data provided.
2. This DSA prohibits **Managed Care Plan** from redisclosing PII provided under this Agreement to a third party unless written permission is received from **CoC HMIS Lead**.
3. This agreement shall continue to be in force until all parties agree to its termination under the provisions in **Article V**.
4. Institutional Review Board (IRB) authorization is not required. If IRB authorization is required, data will not be transferred until and unless such authorization is obtained. Information on **Managed Care Plan** IRB can be found at: **www.website.com**.
5. Upon termination of this agreement, **Managed Care Plan** must destroy, delete, or otherwise permanently remove all copies of the data transferred by **Freddie Hamis**, whether in electronic or physical format. This includes copies in raw form to which additional data have been added, but does not include aggregated output, final analyses, or any reports, charts, graphs, etc., resulting from the analyzed data. **Managed Care Plan** must provide written proof of destruction to **CoC HMIS Lead** within **30 days** of termination.
6. This agreement shall be reviewed at least annually and as required to satisfy changing requirements.
7. There is no cost associated with this agreement.

Article III: Data Specification

Freddie Hamis will supply the following data to **Managed Care Plan** in the manner and frequency described immediately below.

Frequency:	*Describe how often new data will be provided. Is the data only provided once or at regular intervals?*
Method of Transfer:	*Describe the method of transfer. SFTP transfer is the most common way for data match without an Application Programming Interface (API). If an API is preferred, specify that. If the MCP has access to HMIS and can access the data that way, describe how.*
File Format:	*Describe the format in which data will be exchanged (e.g., CSV).*
Date Range:	*Describe the date range for the data to be provided, if applicable.*
Other Filters:	*Describe any additional filters to be applied to the data (e.g., children under 5). Data sharing will be limited to data elements named and described under this agreement.*

Element – Short Name	Element – Long Name	Format
FIRST	Participant's First Name	Narrative
LAST	Participant's Last Name	Narrative
DOB	Participant's Date of Birth	MMDDYYYY
SSN	Participant's Social Security Number, if available	###-##-####
HOUSING_STATUS	Whether participant is housed or unhoused	Options: Housed, Unhoused *Other options may be included.*

Managed Care Plan will in turn supply the following data to **CoC HMIS Lead** for each member who appeared on the CoC's client list, in the manner and frequency described immediately below.

Frequency:	*Describe how often new data will be provided. Is the data only provided once or at regular intervals?*
Method of Transfer:	*Describe the method of transfer. SFTP transfer is the most common way for data match without an API. If an API is preferred, specify that.*
File Format:	*Describe the format in which data will be exchanged (e.g., CSV).*
Date Range:	*Describe the date range for the data to be provided.*
Other Filters:	*Describe any additional filters to be applied to the data (e.g., children under 5). Data sharing will be limited to data elements named and described under this agreement.*

Element – Short Name	**Element – Long Name**	**Format**
FIRST	Participant's First Name	Narrative
LAST	Participant's Last Name	Narrative
DOB	Participant's Date of Birth	MMDDYYYY
SSN	Participant's Social Security Number, if available	###-##-####
HOUSING_STATUS	Whether participant is housed or unhoused	Options: Housed, Unhoused *Other options may be included.*
CIN	The participant's Medi-Cal number	###########
ECM	Whether the participant is enrolled in ECM	Options: Yes, No *Other options may be included.*
CS	Whether the participant is receiving any Community Supports.	Options: Yes, No *Other options may be included.*
CS_LIST	If yes to Community Supports, specify which ones the participant is receiving	Checklist

Discuss with the MCP whether additional information should be included when they return the matched client list and add data elements to this list as appropriate.

Article IV: General Provisions

Nothing in this Agreement shall be construed as authority for any party to make commitments that will bind any other party beyond **Article I** contained herein.
All parties agree:

1. To adhere to all security standards for secure data storage and transmission as expressed: *list out and link to any relevant data security standard(s).*
2. To prohibit and prevent re-disclosure of any other party's data to any entity not covered by this agreement.
3. To prohibit and prevent storage of any party's data on mobile or portable data storage media without:
    a. Documented business necessity approved in writing by the data stewards of all parties.
    b. Documentation that all data storage media are physically and logically secured and acknowledged by an Information Security Officer from each party.
4. That any PII inadvertently or unintentionally received shall be safeguarded, shall not be redisclosed, and there shall be no attempt made to contact any individual identified by such disclosure.
5. To provide immediate notification (within 24 hours of discovery) to all other parties if a breach, loss, theft, or other compromise of sensitive electronic or physical data is suspected. Notification contacts are as follows:
    a. **Managed Care Plan**: *Insert the name, title, phone number, and email address for the appropriate person*.
    b. **CoC**: *Insert the name, title, phone number, and email address for the appropriate person.*

Article V: Termination

Either party may opt out of this Agreement without cause upon **30 days** days written notice to the other party. *Decide and include here what the other party's responsibility is if one party opts out of the Agreement. For example: Does the other party still have to perform any portion of their obligation under the Agreement? Is the Agreement automatically terminated if one party opts out?*

Either party may opt out of this Agreement immediately, via written notice, upon discovery of a data breach suffered by either party.

Either party may suspend its involvement in this Agreement immediately upon discovery of a data breach suffered internally by that party. Suspension of this Agreement shall not last more than **60 days** days and this Agreement must either be reinstated or terminated per the terms of this Agreement by the end of that period. Suspension and reinstatement or termination must include written notice to the other party.

This Agreement shall remain in full effect until terminated as provided herein. *Consider whether you would like to include a certain date when the Agreement terminates or date by which all parties must perform. For example: One year from the signing of the contract.*

This Agreement can be terminated by agreement of both parties at any time. Such agreement to terminate must be documented in writing and provided to both parties.

This Agreement shall automatically terminate upon:

1. Fulfillment of all terms; or
2. When superseded by a subsequent Agreement; or
3. After a period of **2 years**.

This Agreement does not automatically renew but may be extended by agreement of the parties follow-

ing an appropriate review of all terms and conditions.

Article VI: Integration, Modification, and Assignment

This document represents the entire Agreement between both parties. Any modification of these terms must be in writing and signed by both parties. This agreement shall be interpreted in accordance with the laws of the State of California. Signed copies of this agreement, and any modifications, shall be kept on file with **Managed Care Plan** and/or **CoC HMIS Lead**.

SIGNATURES

The undersigned hereby acknowledge and accept the responsibilities, terms, and conditions laid out in this Data Sharing Agreement:

_____	_____
Jane Steward, Data Steward **Managed Care Plan**	**Date**
_____	_____
Freddie Hamis, HMIS Administrator **CoC HMIS Lead**	**Date**

#End of Document#

Appendices:

a. *List here and attach documentation supporting the project (e.g., Memoranda of Understanding, additional relevant Scopes of Work, Technical Specifications) that should be included.*

Needed HMIS Data Elements for Partnering with Managed Care Plans

Homebase
with the support of the California Health Care Foundation

As part of CalAIM, there is a significant push to build and strengthen partnerships between health and homeless systems of care. Continuums of Care (CoCs) and their county partners collect information about people experiencing homelessness in their Homeless Management Information System (HMIS). Much of the data collected are elements required by HUD.

With growing partnerships with Medi-Cal managed care plans (MCPs), HMIS can be an important tool to help coordinate and communicate about clients and MCP members who touch both systems. In many communities, the current HMIS does not require partners to enter detailed information about people's health care coverage or experiences in the health care system. However, there are data elements (sometimes called "data fields") that could be added to HMIS to capture important information to track activity at the cross-section of health and homelessness.

The table below identifies data elements that are valuable for cross-sector data sharing that can better enable partners to work in a more coordinated and collaborative fashion. CoCs should consider asking their HMIS vendors to add these data fields to their local HMIS if they are not already there and should ensure providers collect the information and enter it in HMIS. Where possible, CoCs should coordinate or discuss these with their local MCPs to ensure any new data fields added to HMIS and associated technical specifications are optimized to facilitate data matching or sharing.

Data Element	Importance	Notes
Enrolled in Medi-Cal?	Identifies if client has health coverage through California's Medicaid program or would benefit from help applying for Medi-Cal.	Health Insurance is a Program-Specific Data Element (4.04) required for federal reporting and so should already appear in each community's HMIS. When an HMIS user notes in HMIS that a person is covered by health insurance, they also indicate all insurance sources that apply, one of which is Medicaid. For anyone enrolled in Medi-Cal (California's Medicaid program), that option should be selected.
Medi-Cal managed care plan	For people enrolled in Medi-Cal, identifies the specific MCP for better collaboration.	In some communities, there is more than one MCP to choose from under Medi-Cal. Some CoCs have created MCP programs in HMIS so clients can be enrolled in those programs when they are confirmed to be MCP members. This allows other information (including ECM and Community Supports – see below) to be tracked as services within those programs.
Medi-Cal Client Index number (CIN)	If someone's Medi-Cal MCP is unknown, their Medi-Cal number can be used to help identify what MCP is providing them coverage. Having this number can also help CoC providers assist clients with checking on benefits and ensuring their coverage remains current.	For clients who have their Medi-Cal card, CoCs should consider scanning it and uploading it to HMIS.

Data Element	Importance	Notes
Other insurance	Especially if someone is not enrolled in Medi-Cal, it is helpful to know if they have other insurance. If they do not have Medi-Cal or other insurance, staff can help them apply for health coverage.	This information should already be collected as a matter of practice by CoC providers, under Program-Specific Data Element 4.04. For clients who have their health insurance card, CoCs should consider scanning it and uploading it to HMIS.
Enrolled in Enhanced Care Management (ECM) through their managed care plan? **If yes: name of ECM provider and care manager**	ECM is an important benefit that provides someone to coordinate each person's care. Knowing whether someone is enrolled in ECM and if so, who their ECM provider and care manager is, can help staff enhance coordination of services.	This may not be something a client will know. MCPs can provide this information to HMIS through bi-lateral data sharing. See *Bi-lateral Data Sharing Agreement Between a Continuum of Care and Managed Care Plan* and *Sample Workflow for Continuums of Care and Managed Care Plans to Conduct a Client Data Match* in this Toolkit.
Receiving Community Supports (CS) through their managed care plan? **If yes, for each Community Support, what is the status (options: referred; authorized) and, if authorized, name of provider.**	There are important housing-related Community Supports that clients may be receiving. Identifying the CS services they are getting from their MCP can help ensure non-duplication and maximize the services clients can receive.	This may not be something a client will know. MCPs can provide this information to HMIS through bi-lateral data sharing. This will likely require separate fields/data elements for each kind of Community Support.
Receiving any medical care through street outreach or street medicine?	CalAIM now covers medical professionals who provide services onsite at encampments and sometimes even shelters. Knowing if clients are receiving such care enhances coordination and the ability to track and update how a person is doing on the street.	This may be accomplished by creating Street Outreach and/or Street Medicine programs in HMIS so clients receiving services and care can be enrolled in those programs and additional details can be more easily added and tracked.

Sample Workflow for Continuums of Care and Managed Care Plans to Conduct a Client Data Match

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A critical component of cross-system care coordination is identifying people who are clients of or accessing the resources of each system. Comparing member and client lists manually can be both time consuming and may compromise the privacy of the individuals on the lists. Client information databases that can communicate directly to identify people who appear in both is ideal. However, managed care plans (MCPs) and Continuums of Care (CoCs) maintain their own client management and information systems and although some of the information contained in each system is similar, the differences in the technology and the way information is collected and stored in each make that kind of direct information exchange difficult, if not impossible.

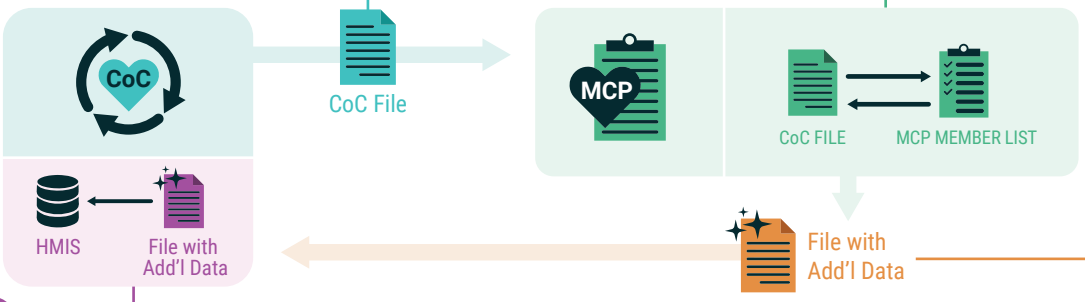
As an alternative, CoCs and MCPs can develop relatively simple protocols to exchange and compare data using technology rather than requiring someone to manually review the information. Below is a simple workflow that CoCs and MCPs can use to accomplish this kind of client data match, as well as a list of recommended data elements to include in the matching process.

The workflow and data element lists contained in this tool are intended to provide practical guidance only, not legal advice or guidance. Each CoC and partner MCP should discuss what data they need to share to accomplish their data match and care coordination goals and should consult with County, MCP, or other legal counsel. Data sharing agreements or new or updated Releases of Information may be necessary before data matching proceeds.

Member matching workflow:

1 CoC provides an electronic file with client list to the MCP
(see page 2 for data elements included)
File can be sent via Secure File Transfer Protocol (SFTP) or MCP can access file directly from HMIS with appropriate access. File format would likely be CSV but can be any file type the CoC and MCP agree upon.

2 MCP matches CoC client data with MCP member list.
Note: This document does not contain the details of how that match process happens, but MCPs should have the technological capability and staff to accomplish it.
- Non-member data is destroyed
- Member data is stored in MCP's data warehouse.



3 MCP sends the member list back to the CoC, with additional relevant information included.
(see page 2 for those additional data elements)

4 CoC uses additional information from MCP to update matched client records in HMIS

CoC HMIS administrator sets up data import tool to import data and update client records

For open members without an MCP program entry in HMIS:
- New program enrollment is created (prior living situation, project start/exit, exit destination are required as HUD Universal Data Elements)
- Date of program enrollment = MCP membership start date
- Include the following data fields (see table below for definitions)
  MCP, MCP Coverage/Plan Type, Member ID, Medi-Cal CIN

For closed members:
- Program Exit is created
- Date of Program Exit = MCP membership end date
- Exit Destination

CoC HMIS administrator uses a data import tool to import or update MCP program enrollments with CalAIM Enhanced Care Management (ECM) and Community Supports (CS) services

For each service in which a member is enrolled:
- New program-level service with service enrollment date as reported by MCP
- ECM and CS services should include Provider

For each service from which a member is discharged or discontinues:
- Program-level service end date is recorded as reported by MCP

The workflow and data element lists contained in this document are based in large part on a workflow and data element technical specifications sheet developed by the Santa Clara County, California Continuum of Care and Santa Clara Family Health Plan working together on HHIP Implementation. Homebase would like to thank them for their permission to build upon and share their work to create this resource for other communities to use.

Information to include in client and members lists when following the workflow above

The following lists are examples for CoCs and MCPs to use to inform their own discussions and plans for conducting data matching. To protect client privacy, CoCs should only provide information that is necessary for MCPs to conduct the initial match. Similarly, MCPs should only send back additional information needed to achieve the CoC and MCP's agreed upon care coordination goals (and should take into account any applicable legal considerations). The lists below assume one such goal is coordination around CalAIM Enhanced Care Management (ECM) and Community Supports (CS) referrals and utilization.

Data elements to include in HMIS client list provided by the CoC to the MCP

The CoC should only include active clients on its list to the MCP. The CoC and MCP should also determine whether to limit the client list in any other way (e.g., to a certain date range) depending on the purposes for the data match (e.g., to meet a Homeless and Housing Incentive Program (HHIP) metric, specific kinds of care coordination, etc.).

- HMIS Client ID
- MCP Member ID (if known)
- First Name
- Middle Name
- Last Name
- Suffix
- Name Data Quality [options: full name reported; partial/street/code name; client doesn't know; client refused; data not collected]
- Date of Birth (DOB)
- DOB Data Quality [options: full DOB reported, approximate or partial DOB reported; client doesn't know; client refused; data not collected]
- Gender [options: female; male; a gender that is not singularly female or male; transgender; questioning; client doesn't know; client refused; data not collected]
- Information Date (date information was collected)

A CoC's HMIS may not contain fields for some of the information an MCP might send back for shared clients (e.g., whether the clients are enrolled in CalAIM Enhanced Care Management or even which MCP clients are enrolled with if the CoC covers a county with multiple Medi-Cal MCPs). Before the CoC can update client records with that information, changes may need to be made to accommodate it. CoCs should determine what would work best for them and their HMIS. This workflow assumes the CoC has created an MCP project within HMIS to enroll clients when they're confirmed to be an MCP member. That allows for ECM and CS information to be added as services within the project.

Data elements for the MCP to include for each matched client when sending the list back to the CoC

- HMIS Client ID
- First Name
- Middle Name
- Last Name
- Suffix
- Date of Birth
- MCP
- MCP Coverage/Plan Type [options: Medi-Cal; Dual Eligible Special Needs Plan]
- MCP Member ID
- CIN (Medi-Cal Client Identification Number)
- MCP Date of Enrollment (Effective Date)
- MCP Date of Exit (Termination Date)
- ECM [options: enrolled; not enrolled]
- ECM Provider
- Date of Enrollment for ECM
- Date of Discharge/Discontinuation for ECM
- For each CalAIM Community Support the MCP and CoC want to coordinate around (e.g., Housing Deposits, Housing Navigation, Housing Tenancy Support, and other housing-related supports):
  - Community Support [insert name of community support] [options: enrolled; not enrolled)
  - Community Support [insert name of community support] Provider
  - Date of Enrollment
  - Date of Discharge/Discontinuation

Medi-Cal & HHIP Coverage for Street Medicine

Homebase
with the support of the California Health Care Foundation

Background

The Department of Health Care Services (DHCS) prioritizes street medicine in both its Housing and Homelessness Incentive Program (HHIP) and the new Medi-Cal CalAIM initiative.

CoCs should be aware of a potential increase or expansion of street medicine programs in their communities, as well as the opportunities for leveraging street-based services (e.g., coordination with homeless outreach teams, ensuring all areas of a CoC are covered, connecting street medicine patients to Coordinated Entry, etc.) This handout provides information about how DHCS defines Street Medicine for purposes of Medi-Cal coverage and HHIP so CoCs can discuss street medicine needs, programs, and coordination opportunities with their local MCPs with this critical context in mind.

In November 2022, DHCS released an All Plan Letter[1] (APL 22-023) that governs Medi-Cal coverage for street medicine. The APL removes many of the barriers that prevented street medicine teams from providing comprehensive care to people living unsheltered.

Before APL 22-023, there was no policy that allowed medical providers to get reimbursed for providing or referring patients to services that people living unsheltered need, unless those services were provided in their clinics, federally-qualified health centers (FQHCs), hospitals, or medical offices. Services provided where people lived with their belongings were most likely uncompensated or paid for through private foundations.

HHIP incentivizes Medi-Cal managed care plans (MCPs) to provide support for street medicine. The one-time HHIP funds can be used to provide resources to communities that wish to stand up a new, robust street medicine program or expand existing programs.

Street Medicine Under CalAIM

The new policies reflected in APL 22-023 serve to address the "clinical and non-clinical needs" of people experiencing unsheltered homelessness. Of utmost importance, Medi-Cal will ***pay street medicine providers for their on-site medical visits*** to care for people living unsheltered.

If medical or social services are provided at shelters, mobile units or RVs, or other sites with a ***fixed, specific location***, they do not qualify as street medicine for purposes of CalAIM (they may be reimbursable through other Medi-Cal initiatives). Services provided in such situations are covered as "mobile medicine," because they require the person experiencing homelessness to visit a health care provider at the fixed location.

Mobile medicine provides care to people experiencing homelessness who live in shelters or who receive their health care some place other than their own personal "lived environment," such as a day center or an emergency shelter.

However, if the mobile unit/RV goes to the individual experiencing unsheltered homelessness in their "lived environment" (e.g., on the street, at an encampment, in their tent by a river), it would be considered "street medicine." Under the DHCS definition, delivery of medical services at a safe parking site, which is not meant for human habitation, would fit the definition of street medicine since the medical provider is providing services to an individual in their lived environment (their car). Street medicine programs are not required to be associated with a brick-and-mortar facility.

DHCS encourages MCPs to adopt their own street medicine guidelines and engage as many providers as possible in street medicine, while still maintaining high quality of care standards.

APL 22-023 allows street medicine providers to become Medi-Cal providers directly. While they recognize the value of mobile medicine, DHCS clearly states that they expect the majority of health and social services provided to individuals experiencing unsheltered homelessness will be through street medicine.

Street medicine includes "[h]ealth and social services developed specifically to address the unique needs and circumstances of unsheltered homeless individuals delivered directly to these individuals in their own environment." Street medicine is provided to an individual experiencing unsheltered homelessness in their "lived environment, places that are not intended for human habitation."

While the provision of medical services on the street will be covered by Medi-Cal, the APL is silent regarding the reimbursement rates. Street medicine may be reimbursed at the same rate as services on site at a facility or medical office.

[1] DHCS shares information or interpretation of changes in policies or procedures through All Plan Letters (APLs). APLs communicate how to operationalize federal or state law changes.

Managed Care Plans & Street Medicine Options

There are multiple ways that MCPs can cover medical services to unsheltered individuals through street medicine:

- Street medicine providers assigned as the primary care providers (PCP) for the individual receiving services;
- Through a direct contract with the MCP as an Enhanced Care Management (ECM) provider;
- As a referring or treating contract provider.

Street medicine provider as PCP

Street medicine providers are licensed medical providers[2] who conduct patient visits outside a clinic or hospital, "directly on the street, in environments where unsheltered individuals may be (such as those living in a car, RV, abandoned building, or other outdoor areas)." They can opt to serve as the individual's PCP in a similar fashion that ob/gyns act as PCPs. They must also:

- Meet eligibility criteria for being a PCP;
- Be qualified and capable of treating the full range of health care issues served by PCPs within their scope of practice; and
- Agree to serve in a PCP role.[3]

Street medicine providers are responsible for all the medical services that would be provided as a Medi-Cal PCP, including preventive services and the treatment of acute and chronic conditions. The range of services includes:

- Basic case management;
- Care coordination and health promotion;
- Support for members, their families, and their authorized representatives;
- Referral to specialists, including behavioral health, community, and social support services, when needed;
- The use of health IT to link services; and
- Provision of primary and preventative services to assigned members.

If an individual street medicine provider meets the PCP qualifications, it is up to the MCP to enroll and establish credentials for the street medicine provider.[4] (There also are additional administrative requirements.)

MCPs must also develop protocols that govern when PCPs identify and transfer members to a higher level of care when the member's needs are higher than the PCP can provide through the street medicine program (e.g., access to emergency medicine, specialty care, mental health services, substance use services, transportation). They need to have protocols in place for "expeditious" referrals to ECM and Community Supports. They must have policies and procedures in place that articulate their 1) process for contracting with street medicine providers; 2) process for ensuring timely access to traditional PCPs and/or specialists; and 3) process to provide transportation to traditional PCPs upon member request.

Other requirements

All street medicine providers serving as PCPs must meet site review and medical record review requirements. If they are associated with a brick-and-mortar facility or a mobile/RV clinic, they must go through a full review. If they are not affiliated with a brick-and-mortar facility, they go through condensed review.

Enrolling a Patient with a Street Medicine Provider

MCPs must clearly communicate with members that street medicine providers are available as PCPs. Street medicine providers must be able to call the MCP while in the company of their member/patient. The MCP must allow the member to choose the street provider as their PCP. The new process potentially overcomes a barrier that existed in the past, which required PCP approval to access a street medicine provider. However, the process of calling together to change the name of the PCP and allow for immediate coverage for services may not be as smooth practically as it is envisioned in the APL.

[2] Doctor (MD/OD), Physician Assistant (PA), Nurse Practitioner (NP), or Certified Nurse Midwife (CNM). For non-physicians, MCPs must ensure compliance with state law/contract requirements re: physician supervision (e.g., supervisor must be a practicing street medicine provider, with knowledge of and experience in street medicine clinical guidelines and protocols).
[3] Street medicine providers are exempt from meeting Medi-Cal time and distance standards, as well as the service location requirement.
[4] Please note that there may be some providers unable to enroll in DHCS's state-level enrollment pathway (APL 22-013) for credentialling. In those circumstances, to become an in-network provider, they must meet alternative criteria for credentialling. See APL 22-023 pages 5-6.

DHCS encourages MCPs to directly contract with street medicine providers. Direct contracts enable providers to skip having to contract with intermediary independent physician/provider associations (IPAs). The street medicine provider would also be able to directly process claims with the MCP (again, skipping the middle administrative agencies). Payments would be between the street medicine provider and the MCP; they would not have to go through a prior authorization process even if the member is assigned to an IPA or medical group for other services.

The main requirement for direct contracting is that the street medicine provider must have the ability to directly authorize and refer their patients to other medically necessary services through the members' appropriate network.

Street medicine providers who are also ECM providers

MCPs can contract with street medicine providers to be ECM providers. When providers are both street medicine and ECM providers, they can directly provide care management, rather than have to refer back to a PCP to do so. They can manage their patients' housing-related supports, social services, mental health services, etc. in addition to their medical care.

If providers opt to be both ECM and street medicine providers, they must be enrolled as Medi-Cal providers and meet all of the ECM provider requirements (have the capacity to provide culturally appropriate and timely in-person care management activities; have formal agreements, IT and data systems/processes to support care coordination/care management).

Street medicine providers who serve only as referring or treating contracted providers

Street medicine providers are not required to take on additional roles as PCPs. They can opt to simply refer or treat through a street medicine program. To refer or treat only, the street medicine provider must have a relationship with the member's PCP or ECM manager so that the member can get referrals to primary care, behavioral health services, and other services as needed. They also must have the ability to communicate and be responsive to care coordination and monitoring of care.

Allowing non-PCP providers to offer street medicine is a significant change, in that the provider does not have to be the assigned PCP of an individual experiencing homelessness to provide care to the individual and get paid for the services.

Housing & Homelessness Incentive Program (HHIP) & Street Medicine

One of the seven priority metrics DHCS defined for HHIP relates to street medicine: Metric 2.1 – Connection with street medicine team providing health care for people who are homeless. The definition of what services are considered "street medicine" is the same as in APL 20-023.

DHCS will provide incentive fund points to MCPs who are able to report progress on street medicine efforts. Specifically, MCPs must report an increase in the proportion of their members receiving street medicine services during the first ten months of 2023 as compared to the last eight months of 2022. See *Understanding HHIP Performance Metrics* in this Toolkit.

For more in-depth information about street medicine efforts in California, please see The California Street Medicine Landscape Survey and Report.

HHIP Expenditure Planning

Moving Beyond the Metrics: Shifting Focus from Earning HHIP Funds to Allocating Them

Homebase

with the support of the California Health Care Foundation

As part of the Housing and Homelessness Incentive Program (HHIP), Medi-Cal managed care plans (MCPs) had to submit an Investment Plan to the Department of Health Care Services (DHCS) to demonstrate how they would achieve HHIP targets and metrics. DHCS required that the Investment Plan be designed in collaboration with MCPs' local Continuums of Care (CoC) and/or county partners. Some MCP established work groups with their local CoCs and counties, participated in CoC meetings, and held ongoing planning discussions to identify needs and gaps in the local homeless system of care.

Investment Plans were created to help MCPs and CoCs and county partners identify the activities most needed in the local community to prevent and end homelessness. The Plans also were driven by activities and investments that would best help the MCPs meet HHIP metrics. The more an activity or investment would help MCPs meet HHIP metrics, the greater potential for pulling down a high percentage of incentive funds. See *Understanding HHIP Performance Metrics* in this Toolkit; see also The Housing & Homeless Incentive Program (HHIP).

MCPs and their local CoC and county partners know the initial activities they will fund to meet HHIP metrics. Many partnerships are in the process of developing agreements and contracts to finalize initial investments and activities, most of which are intended to help the MCPs meet the HHIP metrics and maximize the amount of HHIP incentive funds they'll receive. Though not required by DHCS, the next step for MCPs and their CoC and county partners is to create an Expenditure Plan. The purpose of an Expenditure Plan is to detail the ongoing investments MCPs will make in the local community once they receive their incentive funds from DHCS.

By March 2024, up to 100% of the potential HHIP incentive funds will be distributed to each MCP. Although the funds are flexible, there is an expectation that MCPs will invest the incentive funds back into their local communities to strengthen homelessness response systems. Now is the time for MCPs and their CoC and county partners to develop Expenditure Plans, which will create a road map to invest the HHIP funds towards preventing and ending homelessness.

MCPs and partners will want to develop Expenditure Plans that consider:

- The potential total amount of incentive funds that each MCP serving the local community may be eligible for (assuming they meet all HHIP metrics during Measurement Periods 1 and 2).
- Other sources of funding that may be available in the community (federal, state, municipal, or private funds).
- The HHIP investment activities that have already been identified by the community.
- Additional gaps and needs in the community's homelessness response most in need of additional financial investment that can benefit from a one-time infusion of funding/do not require ongoing funding (e.g., start up costs for a new program, supplies, training).
- In considering the best use of one-time, flexible funding that can be most impactful in the local community, partners may want to discuss the following questions:
  - Should additional funding be placed into existing investment activities or are there other needs in the community that have yet to receive funding as part of HHIP implementation?
  - What existing strategic plans in the local community should be referenced for new ideas?
  - Are there populations or sub-populations of the community that are not currently being served or who are underserved? If so, what new investments could address their needs?
  - Are there opportunities to leverage one-time funding into more permanent investments, such as new affordable and accessible permanent housing? Can MCPs invest in rehabilitation or renovation of a building that a homeless service provider could then operate as PSH moving forward?

In addition to determining the priority areas where the incentive funds will be expended, MCPs and their CoC and county partners will want to populate their Expenditure Plan with details that set the stage for new Memoranda of Understanding (MOUs), data sharing agreements, and contracts that will be necessary to implement the plan.

An Expenditure Plan should:

- Be specific when identifying areas of need. It should provide details such as population impacted, amount of funding required, and expected outcomes.
- Identify how the money should flow to the local community and who should receive it to ensure the greatest impact. For example: Should it go through the CoC? The county? Individual providers? Remain with the MCP?
- Outline the processes that should be in place for providing feedback, sharing ideas with the MCPs, and revising commitments for the areas of investment in the local community.

The **chart below can be used in the initial stages of expenditure planning** to support MCPs, CoCs, counties, and other partners to brainstorm and gather input regarding potential programs and strategies that might be funded using HHIP incentive funds, as well as the gaps or needs to be addressed by each idea, the partners who discussed and reached consensus on the ideas, and additional information or next steps needed to refine the ideas.

Priority Area	Potential Programs or Strategies	Gap or Need Addressed	Additional Information Needed or Next Steps to Refine Ideas	Discussion Participants

Once program and strategy ideas are agreed upon by relevant partners, the simple **Expenditure Plan template below** can be used to capture the community's initial plan for HHIP incentive award funds received. Additional columns can be added as needed (e.g., to indicate the targeted population, responsible parties, status, next steps, etc.), and communities may find that implementation plans may be useful for specific strategies.

Program or Strategy	Description of Activities (2-3 sentences per activity)	Funding to be Allocated ($ amount or percentage of total HHIP award)	Intended Funding Recipient(s) [or whether an RFP or similar process should be used to identify recipient(s)]	Goals, Performance Metrics, and Timeline