HomeBase
Advancing Solutions to Homelessness

The Regional Steering Committee on Homelessness and Housing

for the San Francisco Bay Area

Since 1986, members of the RSC have identified problems that cross county borders and searched for solutions that prevent and end homelessness in all of our communities.

RSC members collectively participate in policy development, peer support, information sharing, training, strategizing and planning.

Friday, January 13, 2017

10:00 am – 2:00 pm

Human Rights Commission

25 Van Ness Street, 8th Floor

San Francisco, CA 94102

AGENDA

Housing & Healthcare Coordination

1. Housing & Healthcare *Is your community maximizing Medi-Cal opportunities to more stably house and better connect your homeless and at-risk clients to health care and other needed services? Learn strategies from Northern California peers who participated in Action Planning Sessions on Housing-Health Care Coordination and hear how they are working to move their implementation plans forward.*

2. Whole Person Care: *An opportunity to learn from communities trying to coordinate health, behavioral health, and social services in a patient-centered manner with the goals of improved beneficiary health and wellbeing through more efficient and effective use of resources.*

3. Federal and State Funding Opportunities: *How has your community responded to the results of the 2016 CoC NOFA competition? How is your community continuing the efforts of the Youth Homelessness Demonstration Project? What are your funding priorities for the FY2017 CoC NOFA?*

Please register at:
http://rscforthesanfranciscobayarea.eventbrite.com

Commonly Used Acronyms

Acronym	Definition
AHAR	Annual Homeless Assessment Report
APR	Annual Performance Report (for HUD homeless programs)
CDBG	Community Development Block Grant (CPD program – federal)
CSBG	Community Services Block Grant
Continuum of Care	Continuum of Care approach to assistance to the homeless
CoC	Federal grant program stressing permanent solutions to homelessness
Con Plan	Consolidated Plan, a locally developed plan for housing assistance and urban development under CDBG and other CPD programs
CPD	Community Planning and Development (HUD Office)
ESG	Emergency Solutions Grant (CPD – federal program)
FMR	Fair Market Rent (maximum rent for Section 8 rental assistance/CoC grants)
HCD	Housing and Community Development (State office)
HEARTH	Homeless Emergency and Rapid Transition to Housing (HEARTH) Act of 2009
HPRP	Homeless Prevention and Rapid Re-Housing
HMIS	Homeless Management Information System
HOME	Home Investment Partnerships (CPD program)
HOPWA	Housing Opportunities for Persons with AIDS (CPD program)
HUD	U.S. Department of Housing and Urban Development (federal)
MHSA	Mental Health Services Act
NOFA	Notice of Funding Availability
PHA	Public Housing Authority
SAMHSA	Substance Abuse & Mental Health Services Administration
SNAPS	Office of Special Needs Assistance Program (HUD office overseeing CoC)
SOAR	SSI/SSDI Outreach, Access, and Recovery (SSI/SSDI Application program)
SRO	Single-Room Occupancy housing units
SSA	Social Security Administration
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
TA	Technical Assistance
TANF	Temporary Assistance to Needy Families
TAY	Transition Age Youth (usually ages 16-24)
VA	Veterans Affairs (U.S. Department of)
VASH	Veterans Affairs Supportive Housing

GLOSSARY OF HOUSING AND HEALTH CARE TERMS

ACRONYM / TERM	DEFINITION / DESCRIPTION
ACA	Affordable Care Act
ACO	Accountable Care Organization. This is a voluntary provider participation model in which groups of doctors, hospitals, and other health care providers come together to give coordinated high quality care to their Medicare patients.
ACT	Assertive Community Treatment. A team-based treatment model that provides multidisciplinary, flexible treatment and support to people with mental illness 24/7.
ASPE	Assistant Secretary for Planning and Evaluation. The principle advisor to the Secretary of the U.S. Department of Health and Human Services on policy development. Responsible for major activities of policy coordination, legislation development, strategic planning, policy research, evaluation, and economic analysis.
Behavioral health	An umbrella term that includes mental health and substance abuse.
CABHI	Cooperative Agreement to Benefit Homeless Individuals. Program funded by SAMHSA, Center for Substance Abuse Treatment and Center for Mental Health Services to help states increase capacity to provide services, permanent housing, and supports for veterans experiencing homelessness and other individuals experiencing chronic homelessness.
Capitation	A method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served, without regard to the actual number or nature of services provided to each person in a set period of time.
CHIP	Children's Health Insurance Program. Offers free or low-cost health coverage for eligible children and other family members.
Chronically Homeless	HUD defines this population as an unaccompanied homeless individual with a disabling condition or a family with at least one adult member who has a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years.
CMS	Centers for Medicare & Medicaid Services. The government agency within the Department of Health and Human Services that directs the Medicare and Medicaid programs. Formerly Health Care Financing Administration.
CMMI	The Center for Medicare & Medicaid Innovation (The Innovation Center)
CoC or Continuum of Care (Housing)	A Continuum of Care is a local or regional system for helping people who are homeless or at imminent risk of homelessness in the community, from homeless prevention to permanent housing.
Continuum of care (Health Care)	Clinical services provided during a single inpatient hospitalization or for multiple conditions over a lifetime. Provides a basis for evaluating quality, cost, and utilization over the long term.
CoC Homeless Providers	Non-profit agencies or State and Local Governments that provide housing and services for homeless persons.

ACRONYM / TERM	DEFINITION / DESCRIPTION
Coordinated Care Initiative (CCI)	Ongoing California demonstration promotinh coordinated health care delivery for seniors and persons with disabilities eligible for both Medicare and Medi-Cal in 7 California counties through Cal MediConnect managed care plans: San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside and San Bernardino. Budgeted to continue through the end of 2017, potentially extended through 2019. http://www.dhcs.ca.gov/dataandstats/statistics/Pages/Medi-Cal_CCI.aspx
Coordinated Entry	A coordinated system across a CoC and its programs to initially assess the eligibility and needs of each individual or family who seeks homeless assistance, and to coordinate the entry and provision of referrals to programs. Through the coordinated entry process, people seeking assistance receive prevention, housing, and/or other related services.
DHCS	CA Department of Health Care Services. DHCS is the state agency responsible for operating Medi-Cal, the state's Medicaid program.
Disability	Per the ADA: With respect to an individual, disability means: (1) a physical or mental impairment that substantially limits one or more majority life activities of such individual; (2) a record of such an impairment; or (3) being regarded as having such an impairment.
Disabling Condition	Per HUD: (1) a disability as a defined in Section 223 of the Social Security Act; (2) a physical, mental, or emotional impairment which is expected to be of long-continued and indefinite duration, substantially impedes an individual's ability to live independently, and of such a nature that the disability could be improved by more suitable conditions; (3) a developmental disability as defined in Section 102 of the Developmental Disabilities Assistance and Bill of Rights Act; (4) the disease of acquired immune deficiency syndrome or any condition arising from the etiological agent for acquired immune deficiency syndrome; or (5) a diagnosable substance abuse disorder.
DSRIP Program	Delivery System Reform Incentive Payment Program. Program that provides states with funding that can be used to support hospitals and other providers in changing how they provide care to Medicaid beneficiaries.
Dual eligible	A person who is eligible for two health insurance plans, often referring to a Medicare beneficiary who also qualifies for Medicaid (Medi-Cal) benefits.
DV	Domestic Violence
Emergency Shelter (ES)	Any facility that the primary purpose of which is to provide temporary or transitional shelter for the homeless in general or for specific subpopulations of the homeless, while they prepare to move into more stable housing. The housing and services are typically provided for up to 90 days or until specific goals are accomplished by the client.
EMS	Emergency medical services. Services utilized in responding to the perceived individual need for immediate treatment for medical or psychological illness or injury.
ER/ED	Emergency Room/Emergency Department
FMR	Fair Market Rent. The amount of money a property would rent or lease for if it was on the market at a given time.
FMS	Financial Management Services.

ACRONYM / TERM	DEFINITION / DESCRIPTION
Federal Financial Participation (FFP)	A Title XIX (Medicaid) program allowing states to receive partial reimbursement for activities meeting FFP objectives.
Federal Poverty Level (FPL)	Measure of income level issued annually by the Department of Health and Human Services, used to determine eligibility for certain programs and benefits. For 2015, the FPL is $11,770 for individuals; $15,930 for a family of two; $20,090 for a family if 3; $24,250 for a family of four.
Fee for Service	Method of billing for health care services under which a provider charges separately for each patient encounter or service rendered.
FQHC	Federally Qualified Health Center. Federally funded nonprofit health centers or clinics that service medically underserved areas and populations and are eligible to receive cost-based Medicare and Medicaid reimbursement. FQHCs provide primary care services regardless of ability to pay.
HCD	CA Department of Housing and Community Development. This state agency is responsible for providing leadership, policies and programs to preserve and expand safe and affordable housing opportunities and promote strong communities in California.
HCH	Health Care for the Homeless.
Health Homes Program (HHP) or Health Home for Patients with Complex Needs (HHPCN)	Ongoing California initiative still in the planning stages and has not yet received federal approval. It's intended to develop a network of providers to integrate and coordinate primary, acute, and behavioral health services for the highest risk Medi-Cal enrollees. *Implementation roll-out schedule includes Marin, Napa, Sonoma, and Solano in Jan-July 2017, but HHP implementation is not currently scheduled for Contra Costa.* http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx
HHS	U.S. Department of Health and Human Services
HMIS	Homeless Management Information System. A computerized data collection system that tracks services received by homeless people, helps identity gaps in services within the CoC, and allows for greater collaboration among service providers by providing a "history" of a homeless person's involvement in the system of care.
Home- and Community-Based Services (HCBS)	Any care or services provided in a patient's place of residence or in a non-institutional setting located in the immediate community.
HOPWA	Housing Opportunities for Persons with AIDS. Federal program dedicated to the housing needs of people living with HIV/AIDS. Under the program HUD makes grants to local communities, State, and nonprofit organizations for projects that benefit low-income persons living with HIV/AIDS and their families.
Housing First	An approach to ending homelessness that centers on providing people experiencing homelessness with housing as quickly as possible, and then providing services as needed. Key elements are a low threshold for entry and no clinical prerequisites such as completion of a course of treatment or evidence of sobriety.
HRSA	Health Resources and Services Administration. The primary federal agency for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. Part of the U.S. Department of Health and Human Services.

ACRONYM / TERM	DEFINITION / DESCRIPTION
HUD	U.S. Department of Housing and Urban Development
Look-Alikes	There are 70 health centers meeting all HRSA Health Center Program requirements, but that do not receive Health Center grant funding.
Mainstream Programs	Programs that are not specifically targeted to homeless people, including Medicaid, food stamps (SNAP), Social Security Insurance, Social Security Disability Insurance, Workforce programs, Temporary Aid for Needy Families (TANF), etc.
Managed Care Organization (MCO)	A health care delivery system consisting of affiliated and/or owned hospitals, physicians, and others that provide a wide range of coordinated health services; an umbrella term for health plans that provide health care in return for a predetermined monthly fee and coordinate care through a defined network of physicians and hospitals.
Medicaid	A Federally aided, State-operated and administered program that provides medical benefits for certain indigent or low-income persons in need of health care. Subject to broad Federal guidelines, States determine benefits covered, program eligibility, rates of payment for providers, and methods of administering the program.
Medi-Cal	California's Medicaid program. The state and federal governments finance it equally.
Medi-Cal 2020 Waiver	California's 1115 Waiver Renewal. The Centers for Medicare and Medicaid Services approved it on Dec. 30, 2015. http://www.dhcs.ca.gov/provgovpart/Pages/medi-cal-2020-waiver.aspx
ONDCP	Office of National Drug Control Policy. Component of the Executive Office of the President of the United States. Its goal is to establish policies, priorities, and objectives to eradicate illicit drug use, manufacturing, and trafficking; drug-related crime and violence; and drug-related health consequences in the U.S.
Outreach	The initial and most critical step in connecting or reconnecting a homeless person to needed health, mental health, recovery, social welfare, and housing services. Outreach is viewed as a process rather than an outcome, with a focus on establishing rapport and a goal of engaging homeless persons into accepting services and housing.
PATH	Projects for Assistance in Transition from Homelessness. Administered by SAMHSA's Center for Mental Health Services. Provides services to people with serious mental illness, including those with co-occurring substance use disorders, who are experiencing homelessness or at imminent risk of becoming homeless.
Permanent Supportive Housing (PSH)	Provides long-term (not time-limited), safe, and decent housing for homeless persons with disabilities, enabling independent living. May be provided in a single structure or at scattered sites.
PHA	Public Housing Authority
PLWHA	Persons living with HIV/AIDS
Point-in-Time (PIT) Count	A one-day statistically reliable unduplicated count of sheltered and unsheltered homeless individuals and families in a specific area. CoCs are only required to conduct a one-day point-in-time count every two years (biennially) however, HUD strongly encourages CoCs to conduct an annual point-in-time count, if resources allow.

ACRONYM / TERM	DEFINITION / DESCRIPTION
Presumptive Eligibility	Gives an uninsured individual access to immediate, temporary Medicaid if they appear to be eligible, allowing the person to access health care services without having to wait for their application to be fully processed. If someone is deemed "presumptively eligible," the full eligibility process is performed.
Primary Care Association (PCA)	A group of clinics in a defined geographic location that offers care for people who are uninsured or who lack means to pay for care. A state's PCA is the umbrella organization for FQHCs in that state.
Rapid Re-Housing (RRH)	Places a priority on moving a family or individual experiencing homelessness into permanent housing as quickly as possibly, ideally within 30 days of the client becoming homeless or entering a program. Duration of financial assistance may vary.
Respite care (health care system)	Care given to a hospice patient by another caregiver so that the usual caregiver can get rest.
Respite/Recuperative care (housing assistance system)	Program that provides short-term medical care and case management to homeless persons recovering from acute illness or injury whose condition would be exacerbated by being discharged to the street or a shelter.
Ryan White HIV/AIDS Program	Works with cities, states, and local community-based organizations to provide services to people living with HIV/AIDS who do not have sufficient health care coverage or financial resources. The program is administered by HRSA's HIV/AIDS Bureau (HAB).
Safe Haven	Program that serves hard-to-reach homeless persons who have severe mental illness, are on the streets, and have been unable or unwilling to participate in supportive services. Safe Havens do not require participation in services and referrals as a condition of occupancy.
SAMHSA	Substance Abuse and Mental Health Services Administration. Agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation. Its mission is to reduce the impact of substance use and mental illness on America's communities.
SSDI	Social Security Disability Insurance. Pays monthly benefits to workers who are no longer able to work due to significant illness or impairment expected to last at least a year or to result in death within a year. Benefits are based on past earnings.
SSI	Supplemental Security Income. A Federal cash assistance program for low-income aged, blind, and disabled individuals.
SOAR Program	SAMHSA's SSI/SSDI Outreach, Access, and Recovery Program. The program seeks to end homelessness through increased access to SSI/SSDI income supports, and is designed to increase access to the disability income benefit programs administered by the Social Security Administration for eligible adults who are experiencing or at risk of homelessness and have a mental illness, medical impairment, and/or a co-occurring substance use disorder.
Supportive Services Only (SSO)	Projects that address the service needs of homeless persons. Projects are classified as this component only if the project sponsor is not also providing housing to the same persons receiving the services. SSO projects may be in a structure(s) at a central location.

ACRONYM / TERM	DEFINITION / DESCRIPTION
STC	Special Terms and Conditions (e.g., regarding Medi-Cal 2020 Waiver). They provide conditions and limitations on waivers of statutory Medicaid requirements to allow deviation from the approved State Medicaid Plan; and on expenditure authorities to authorize expenditures not otherwise matchable.
Tenant-Based Rental Assistance (TBRA)	Provides homeless families and individuals with very low and extremely low incomes with housing assistance. TBRA programs allow participants to choose their own housing and retain the rental assistance if they move.
TBI	Traumatic Brain Injury. TBI is an insult to the brain caused by an external physical force, for example; fall, motor vehicle accident, assault, sports related, IED explosion.
Transitional Housing (TH)	Type of supportive housing used to facilitate the movement of homeless individuals and families to permanent housing. It is housing in which homeless persons may live up to 24 months and receive supportive services that enable them to live more independently. The supportive services may be provided by the organization managing the housing or provided by other public or private agencies.
Unsheltered Homeless	Someone who is living on the streets or in a vehicle, encampment, abandoned building, garage, or any other place not normally used or meant for human habitation.
USICH	United States Interagency Council on Homelessness
VI-SPDAT	Vulnerability Index-Service Prioritization and Decision Assistance Tool. An evidence-based, street-use-informed assessment tool that is designed to help providers determine the most appropriate housing intervention for a particular individual or family.
Whole Person Care (WPC)	5-year California regional pilot program authorized under Medi-Cal 2020 Waiver. Designed to test locally-based initiatives to coordinate physical health, behavioral health, and social services for vulnerable, high multiple health care system user, Medi-Cal beneficiaries who continue to have poor outcomes. Provides up $1.5 billion in federal funds over five years to match local public funds for the WPC pilots. May target individuals experiencing or at risk of homelessness who have a demonstrated medical need for housing and/or supportive services. ***Applications due to DHCS July 1st.*** http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx

Note: This document was generated by TA providers to support direct TA for CA Chronic Homeless Policy Academy communities, and incorporates information from multiple sources without attribution to the original source material. The information was collected from publicly available online sources, and therefore not every piece of information may be completely accurate or up to date.

FEDERAL FUNDING & ADVOCACY OPPORTUNITIES

RESULTS OF THE FY 2016 NOFA COMPETITION & PRIORITIES FOR 2017

On December 20, 2016, the Department of Housing and Urban Development (HUD) announced the results of the FY 2016 Continuum of Care Program Competition. Around $1.95 billion of funding was awarded to CoCs across the nation and U.S. territories, funding more than 7,600 homeless housing and service programs. Of that amount, HUD awarded roughly **$116 million** to CoCs in the Bay Area.

Both a reduction in the amount of projects in Tier 2 this year and changes in Tier 2 scoring accounted for less variation in awards. The average percentage of 2016 ARD awarded was **approximately 104%,** not including certain outliers. ARD award percentages for CoCs in the nine Bay Area counties averaged around 108%, which was slightly skewed upwards by awards in several counties who successfully petitioned for increased fair market rents (FMRs) for certain counties to some but not all Bay Area counties.

FAIR MARKET RENT AWARDS

This year, HUD granted awards based on 2016 FMRs rather than 2017 FMRs that took effect on October 1, 2016. HUD justified this departure from expected practice by the fact that awards are based on the FMRs in place when the competition closes. The competition closed in September; new FMRs take effect in October of each year. The failure to increase awards based on 2017 FMRs will result in a substantial hardship in areas where FMRs already fail to keep pace with rising cost of housing.

In 2015, Alameda and Contra Costa Counties commissioned a study to increase FMRs. HUD accepted the findings of that study and increased FMRs of those communities by 35%. Those FMR increases are reflected in 2016 awards, resulting in an increase in competition awards that appears disproportionate to those of neighboring CoCs.

INTERESTS OF THE MOMENT AND LOOKING AHEAD

HUD Priorities for 2017: Youth, Veterans, and the Point-In-Time Count

In a recent HUD publication, HUD stated that it and federal partners agreed to establish **2017 as the baseline year for measuring progress in ending youth homelessness in the context of the Point-In-Time (PIT) Count**. This means that as we measure national and local progress on ending youth homelessness with the PIT count, 2017 will be used as the initial comparison year. To help communities prepare for the PIT count, the U.S. Interagency Council on Homelessness (USICH) hosted a **webinar on promising practices for counting youth**, while HUD published various other sources to aid communities in identifying youth.

Additionally, as ending homelessness among veterans remains a top priority for HUD, HUD published a **Veterans HIC/PIT Count Guidance Tool**, aimed at fostering a better understanding among CoC, VA and other partners about their roles in conducting their local Housing Inventory Count (HIC) and PIT Count. This tool also provides guidance on what projects and persons should be included, and how this data should be reported. As the PIT Count has been specified as the primary source of data to establish this benchmark, it seems that HUD has indicated increased confidence in the PIT Count as an important tool to assess the current state of homelessness.

Question for Discussion:

Based on the results of the 2016 CoC NOFA Competition, what will your CoC prioritize for 2017?

National Alliance to End Homelessness: Family & Youth Homelessness Conference

The National Alliance to End Homelessness (NAEH) is hosting a conference February 23-24, 2017, in Houston, Texas, where participants can learn more about priorities targeted towards ending homelessness for families and youth in FY 2017. Attendees will discuss the latest perspectives on housing and intervention strategies, including rapid-rehousing, crisis response system development, and federal policy goals for Congress; workshops will specifically touch on topics such as the role of emergency shelters for families in a crisis response system; using program- and system-level performance measures; coordinated community responses and lessons from the 100-day challenges; and what opportunities exist under Medicaid to serve families and youth, among others.

Question for Discussion:

Is anyone from your community planning to attend the upcoming NAEH Conference? If so, what topics from the agenda interest you most and what do you hope to learn?

Preserving Medicaid and its Role in Ending Homelessness

On January 11, 2017, a webinar conducted jointly by the NAEH and the National Healthcare for the Homeless Council (NHCHC) discussed the impact to Medicaid should the Affordable Care Act be repealed in its entirety by the incoming administration.

The expansion of Medicaid through the ACA has had a significant impact on securing insurance coverage and access to services for those who are low-income and experiencing homelessness. While intended to be national, the 2012 SCOTUS ruling essentially made it optional for states; according to the speakers, **Health Care for the Homeless clients are 5x as likely to get insurance if living in a covered state.**

If the ACA is removed entirely, with nothing else in place, all states will have the ability to include/exclude categories of populations for coverage under Medicaid; because the Medicaid expansion provides eligibility based solely on income, and no federal department considers addiction to be a "disability" other than HUD, **those covered under the expansion who can only claim substance abuse as a disability are in danger of losing coverage/services if the ACA is repealed.**

For those interested in advocacy efforts to preserve the Medicaid expansion, please visit http://cqrcengage.com/naeh for more information.

CONTINUING EFFORTS OF THE YOUTH HOMELESSNESS DEMONSTRATION

On August, 22, 2016, HUD announced a Notice of Funding Availability (NOFA) for the Youth Homeless Demonstration Program (YHDP) for CoC Collaborative Applicants. The Youth NOFA was designed to reduce the number of youth experiencing homelessness by funding the development of a coordinated community approach to prevent and end youth homelessness in ten communities (four rural) around the United States; the deadline for submission passed on November 30, 2016, and HUD estimated that announcement of the awards for the 10 selected communities will be released winter of 2017, anticipated soon.

After awards are announced, HUD's timeline for 2017 Youth NOFA project planning and implementation includes 1) developing a coordinated community plan; 2) applying for

projects on a rolling basis on *e-snaps*; 3) and engaging with dedicated technical assistance (TA) providers, who will advise the planning and implementation of the coordinated community plan. For those who participated in the Youth NOFA competition, **how is your community continuing the efforts of the Youth Homelessness Demonstration Program, and what have been your experiences so far?**

Questions for Discussion:

- What challenges does your community face in keeping parties engaged in the effort to engage youth and youth providers?
- How have you incorporated continuing efforts from the YHDP application into the Point-In-Time (PIT) Count?
- How is your community using the PIT Count to engage youth providers?
- How is your community using the PIT Count to engage health providers?

HEALTH CARE SYSTEM OVERVIEW: RESOURCES AND DELIVERY

The information in this document is intended primarily to provide people working in subsidized housing and homeless assistance systems basic information about the health care system, including existing health care resources that may benefit their clients. It is also intended to help facilitate strategic discussions between and among housing, health care, and other service providers about ways to creatively take advantage of existing and emerging healthcare resources. The following information is covered:

Health Care Resources

- Federally Qualified Health Centers: Community Health Centers; Health Care for the Homeless
- Rural Health Resources
- Indian Health Resources
- Veteran Health Resources
- HIV/AIDS Health Resources
- Behavioral Health Resources
- Other Resources for the Uninsured
- Medicaid/MediCal

Health Care Delivery

- Managed Care
- Patient-Centered Medical Homes
- Health Homes

Partnership Opportunities

- Managed Care Organizations and Accountable Care Organizations
- Public Hospitals and Health Systems
- County Health Departments

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A variety of health care resources for low-income people exist at the federal and state level. These resources can take the form of health care directly accessible by individuals or funding that flows through organizations that provide health care and related services. Accessing certain resources requires enrollment (and re-certification) based on specific, documented eligibility criteria. As with housing resources, many health care resources focus on particular populations, such as people experiencing homelessness, people living with HIV/AIDS, veterans, or people with disabilities.

The information presented in this worksheet is intended primarily for housing agencies and providers to gain a basic understanding of the health care resources available for people living with HIV/AIDS and people experiencing homelessness, the systems through which health care is delivered and funded, and the ways in which people living with HIV/AIDS and people experiencing homelessness can access the health care services they need.

HEALTH CARE RESOURCES

FEDERALLY QUALIFIED HEALTH CENTERS (FQHCS)[1]

The Federal Health Center Program serves medically underserved populations or areas, works with special populations, and provides for enhanced Medicaid reimbursement. The four types of health centers are: (1) Community Health Centers; (2) Health Care for the Homeless; (3) Migrant Health Centers; and (4) Public Housing Primary Care Health Centers. Details about Community Health Centers and Health Care for the Homeless Programs are below.

COMMUNITY HEALTH CENTERS[2]

Community Health Centers (CHCs) deliver comprehensive, high-quality preventative and primary health care to patients regardless of their ability to pay. They also provide oral health and behavioral health care tailored to the needs of the communities they serve. CHCs offer a sliding fee discount based on income.

HEALTH CARE FOR THE HOMELESS (HCH) PROGRAMS[3]

HCH Programs emphasize a multi-disciplinary approach to delivering care to homeless persons, combining aggressive street outreach with integrated systems of primary care, mental health and substance abuse services, case management, and clinical advocacy. Emphasis is placed on coordinating efforts with other community health providers and social service agencies.

RURAL HEALTH RESOURCES

Critical Access Hospitals (CAHs) and Rural Health Clinics (RHCs) are the safety net providers for rural and remote communities.

Critical Access Hospitals (CAHs)[4]

"Critical Access Hospital" is a designation given to certain rural hospitals by the Centers for Medicare and Medicaid Services (CMS). The CAH designation is designed to reduce the financial vulnerability of rural hospitals and improve access to healthcare by keeping essential services in rural communities. This is accomplished through cost-based Medicare reimbursement.

To ensure that CAHs deliver services to improve access to rural areas that need it most, restrictions exist concerning what types of hospitals are eligible for the CAH designation. The primary eligibility requirements for CAHs are:

- 25 or fewer acute care inpatient beds
- Location more than 35 miles from another hospital
- Maintained annual average length of stay of 96 hours or less for acute care patients
- 24/7 emergency care services

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[1] National Association of Community Health Centers, "So You Want to Start a Health Center…? A Practical Guide for Starting a Federally Qualified Health Center," July 2011: 1, http://www.nachc.com/client/documents/Starting%20a%20FQHC%20Manual-September%202011.pdf.
[2] Idaho Primary Care Association, "What is a Community Health Center?", 2015, http://www.idahopca.org/community-health-centers#what-are-community-health-centers.
[3] National Association of Community Health Centers, "Health Care for the Homeless," http://www.nachc.com/homeless-healthcare.cfm.
[4] Rural Health Information Hub, "Critical Access Hospitals (CAHs), https://www.ruralhealthinfo.org/topics/critical-access-hospitals.

Rural Health Clinics (RHCs)[5]

A Rural Health Clinic is a federally qualified health clinic (but not a part of the FQHC Program) that is certified to receive special Medicare and Medicaid reimbursement. CMS provides advantageous reimbursement to increase rural Medicare and Medicaid patients' access to primary care services.

CMS reimburses RHCs differently than it does other facilities. CMS is required to pay RHCs using a prospective payment system (PPS) rather than a cost-based reimbursement system. RHCs receive an interim payment from Medicare, and at the end of the year, this payment is reconciled using the clinic's cost reporting. For services provided to Medicaid patients, states can reimburse using PPS or by an alternative payment methodology that results in a payment equal to what the RHC would receive under PPS. Regardless of whether the patient sees a mid-level provider or a physician, the RHC must receive the same amount for its services.

INDIAN HEALTH SERVICES[6]

The Indian Health Service (IHS), an agency within the Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally-recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. The IHS is the principal federal health care provider and health advocate for Indian people, and its goal is to raise their health status to the highest possible level. The IHS provides a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaska Natives who belong to 567 federally recognized tribes in 35 states.

VETERAN HEALTH RESOURCES

Veterans Health Administration[7]

The Veterans Health Administration is the largest integrated health care system in the United States, providing care at 1,233 health care facilities, including 168 VA Medical Centers and 1,053 outpatient sites of care of varying complexity (VHA outpatient clinics), serving more than 8.9 million Veterans each year.

San Francisco VA Health Care System

The San Francisco VA Health Care System is a comprehensive network that provides health services to Veterans in San Francisco and surrounding communities, including Marin, Napa, and Sonoma counties, through the San Francisco VA Medical Center (SFVAMC) and six community-based outpatient clinics. SFVAMC has been selected as a Community Resource and Referral Center, one of only 12 locations designed to serve homeless and at-risk for homeless Veterans and their families.

The following programs are offered through both the VA Northern California Health Care System and San Francisco VA Health Care System. Availability of programs at individual VA medical facilities, including community-based outpatient clinics, may vary.

[5] U.S. Department of Health and Human Services Health Resources and Services Administration, "What are Rural Health Clinics (RHCs)?", 2015, http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/ruralclinics.html.
[6] Indian Health Services, "About IHS," https://www.ihs.gov/aboutihs/
[7] U.S. Department of Veterans Affairs, "Veterans Health Administration," www.va.gov/health/aboutVHA.asp and U.S. Department of Veterans Affairs, "Homeless Veterans – Health Care," http://www.va.gov/homeless/health_care.asp

Health Care for Homeless Veterans (HCHV) Program

The HCHV program serves as the hub for a myriad of housing and other services which provide the VA a way to outreach and assist homeless Veterans by offering them entry to VA care. The central goal is to reduce homelessness among veterans by conducting outreach to those who are the most vulnerable and are not currently receiving services and engaging them in treatment and rehabilitative programs. HCHV's Contract Residential Treatment Program ensures that Veterans with serious mental health diagnoses can be placed in community-based programs that provide quality housing and services.

Homeless Patient Aligned Care Teams (H-PACTs) Program

The Homeless Patient Aligned Care Teams (H-PACTs) Program implements a coordinated homeless primary care model that focuses on improving access, care coordination, and quality of treatment for alcohol and other substance use for veterans experiencing or at risk of homelessness. H-PACTs provide a coordinated "medical home" specifically tailored to the needs of homeless Veterans, integrating clinical care with the delivery of social services.

Health Care for Re-Entry Veterans Program

The Health Care for Re-Entry Veterans Program helps incarcerated Veterans successfully rejoin the community through supports including those addressing mental health and substance use problems.

Homeless Veterans Dental Initiative

The Homeless Veterans Dental Initiative provides dental treatment for eligible Veterans in a number of programs: Domiciliary Residential Rehabilitation Treatment, VA Grant and Per Diem, Compensated Work Therapy/Transitional Residence, Healthcare for Homeless Veterans (contract bed), and Community Residential Care.

HIV/AIDS HEALTH RESOURCES

Ryan White HIV/AIDS Program[8]

The Ryan White HIV/AIDS Program provides a comprehensive system of care that includes primary medical care and essential support services for people living with HIV who are uninsured or underinsured. The Program works with cities, states and local community-based organizations to provide HIV care and treatment services to more than 512,000 clients in the U.S. each year.

Part A

Part A provides assistance to Eligible Metropolitan Areas (EMAs) and Transitional Grant Areas (TGAs) that are most severely impacted by the HIV epidemic.

Part B

Part B provides grants to State departments of health or other State and U.S. Territories which administer public health programs and services. Part B grants include a base grant, the AIDS Drug Assistance Program (ADAP) award, ADAP supplemental grants, grants to State for Emerging Communities and an award for Minority AIDS initiative activities.

The AIDS Drug Assistance Program (ADAP) provides free medications for the treatment of HIV/AIDS and opportunistic infections. The drugs provided through ADAP can help people with HIV/AIDS to live longer and

[8] U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), HIV/AIDS Program, "Ryan White HIV/AIDS Program Parts," http://hab.hrsa.gov/abouthab/partd.html

treat the symptoms of HIV infection. ADAP can help people with partial insurance and those who have a Medicaid spend down requirement.

Part C

The Part C Early Intervention Services (EIS) component funds comprehensive primary health care in outpatient settings for people living with HIV disease.

Part D

Ryan White HIV/AIDS Program Part D grant recipients provide outpatient ambulatory family-centered primary and specialty medical care and support services for women, infants, children, and youth living with HIV.

BEHAVIORAL HEALTH RESOURCES

Projects for Assistance in Transition from Homelessness (PATH)[9]

The Substance Abuse and Mental Health Services administration (SAMHSA) operates the grant program Projects for Assistance in Transition from Homelessness (PATH), which provides assistance to individuals who are homeless and have serious mental illnesses. PATH funds are distributed to states, which then contract with local public or non-profit organizations to fund services for homeless individuals.
Among the services eligible for funding under PATH are outreach services, screening and diagnostic treatment services, habilitation and rehabilitation services, community mental health services, alcohol and drug treatment services staff training, case management services, supportive and supervisory services in residential settings, referrals for primary health services, job training, educational services, and relevant housing services.

Additionally, many community health centers and free clinics offer free or low-cost mental and behavioral health services.

OTHER HEALTH RESOURCES FOR UNINSURED RESIDENTS

Free Clinics[10]

Free health and medical clinics offer services free of cost or for a nominal fee to persons who have limited income, no health insurance, or do not qualify for Medicaid or Medicare.

Clinic Profile: RotaCare Bay Area Inc.

RotaCare Bay Area Inc. is a non-profit organization that provides free medical care to those with the greatest need and the least access to medical care. RotaCare operates 12 clinics, including at locations in Concord, Pittsburg, Richmond, and San Rafael. All RotaCare healthcare services are free to the patient including urgent care, medical exams, diagnostic testing, lab testing, and most pharmaceuticals.

Operation Access

Operation Access (OA) enables Bay Area health care providers to donate vital surgical and specialty care to people in need. Operation Access serves community clinic patients in Contra Costa, Marin, Napa, Solano, and Sonoma counties by bringing together medical professionals and hospitals to provide donated outpatient surgical and specialty care for the uninsured and underserved. Through work with local physicians, hospitals and medical centers, hundreds of people in need receive vital surgical and specialty care free of charge every year.

[9] Benefit.gov, "Projects for Assistance in Transition from Homelessness (PATH)", https://www.benefits.gov/benefits/benefit-details/728
[10] Mental Health America, "Paying for Care," http://www.mentalhealthamerica.net/paying-care

County Medical Services Program

The County Medical Services Program (CMSP) provides limited-term health coverage for uninsured low-income, indigent adults that are not otherwise eligible for other publicly funded health programs. Thirty-five primarily rural California counties participate in CMSP.

Eligibility is limited to residents ages 21 to 64 with income at or below 200 percent of the FPL. Enrollees need not have a "medical need" (a chronic or acute health condition that requires medical attention to prevent death, disability, significant illness, or pain) to get coverage. Undocumented residents only have access to emergency services through CMSP.

CMSP coverage is similar to Medi-Cal, with some exclusions, such as pregnancy-related services; long-term care facility services; services of chiropractors, acupuncturists, psychologists, licensed clinical social workers, or marriage and family therapists. Only limited coverage of eye appliances is provided, but CMSP does cover adult dental care.

MEDICAID[11]

Overview: Historically, Medicaid eligibility was restricted to specific categories of low-income individuals, such as children, their parents, pregnant women, the elderly, or individuals with disabilities. In most states, adults without dependent children were ineligible for Medicaid, regardless of their income, and income limits for parents were very low. The Affordable Care Act (ACA) extended Medicaid to nearly all nonelderly adults with incomes at or below 138% of poverty (about $32,500 for a family of four in 2013). All states previously expanded eligibility for children to higher levels than adults through Medicaid and the Children's Health Insurance Program (CHIP).

California State Medicaid Plan: Medi-Cal

Medi-Cal is California's Medicaid program. California was an early adopter of the ACA; the state implemented an early Medicaid expansion through its Low-Income Health Program (LIHP) and was the first to create a state-based Marketplace. Leading up to full implementation of the ACA and during the first year of major coverage expansions, California actively pursued opportunities to expand coverage for residents. The state's 2010 "Bridge to Reform" 1115 Medicaid Demonstration Waiver included early expansion of Medicaid in most counties through the Low-Income Health Program (LIHP), and in 2014, Medi-Cal coverage was expanded statewide to low-income citizens and legal immigrants. Middle-income residents are eligible for premium subsidies to purchase coverage through Covered California. As of June 2015, Medicaid eligibility in California covers almost all nonelderly parents and non-disabled adults up to 133% of the federal poverty level.

Starting in May 2016, 170,000 undocumented immigrant children in California will have access to Medi-Cal. Governor Jerry Brown signed SB4 into law in October 2015, and it eliminates the immigration status requirement for Medi-Cal eligibility for California residents 18 and under. As long as they qualify based on household income, they'll be eligible for coverage.

Medicaid Enrollees and Expenditures: In California, coverage gains have been substantial, with 2.7 million people gaining Medi-Cal coverage and nearly 1.7 million people determined eligible for enrollment through Covered California between October 2013 and September 2014. In FY2013, total Medicaid spending in the state of California was estimated at over $61 billion dollars. Medicaid spending is highest in California for disabled enrollees (42%), followed by aged enrollees (23%) and children (21%). Medicaid costs are shared by

[11] The Henry J. Kaiser Family Foundation, "How Will the Uninsured Fare Under the Affordable Care Act?", April 7, 2014, http://kff.org/health-reform/fact-sheet/how-will-the-uninsured-fare-under-the-affordable-care-act/.

the state and the federal government, with the federal government paying 50% of the cost of California Medicaid.

How care is delivered in California Medicaid: The majority of Medi-Cal beneficiaries receive their health care through a managed care plan. California uses six different models of managed care, which vary with respect to how many plans operate in a county, whether the plans are private or county-operated, and whether there is a fee-for-service option. Each county is served by a single managed care model. In 35 counties, individuals may choose from between two and five plans, with at least one commercial plan option. In 22 counties, everyone is in the same managed care plan that is operated by the county, and one county (San Benito) offers a choice between one commercial plan and traditional fee-for-service.

The waivers presented below may be relevant to certain subpopulations of people experiencing homelessness.

Home and Community Based Services Waiver Programs[12]

The 1915(c) waivers are one of many options available to states to allow the provision of long term care services in home and community based settings under the Medicaid Program. States can offer a variety of services under an HCBS Waiver program. Programs can provide a combination of standard medical services and non-medical services. Standard services include but are not limited to: case management (i.e. supports and service coordination), homemaker, home health aide, personal care, adult day health services, habilitation (both day and residential), and respite care. States can also propose "other" types of services that may assist in diverting and/or transitioning individuals from institutional settings into their homes and community.

California has eight Medicaid 1915(c) HCBS Waivers:

1. **CA HCBS Waiver for Californians w/DD (0336.R03.00)**

Provides behavioral intervention, community living arrangements, day service, home health aide, homemaker, prevocational services, respite care, supported employment (enhanced habilitation), chore, communication aides, community-based training, dental, environmental accessibility adaptations, FMS, non-medical transportation, nutritional consultation, optometric/optician services, PERS, prescription lenses and frames, psychology services, skilled nursing, specialized medical equipment and supplies, specialized therapeutic services, speech/hearing and language services, transition/set up expenses, and vehicle mods and adaptations for **individuals w/autism, developmental disabilities, and intellectual disabilities, of all ages.**

2. **CA Nursing Facility/Acute Hospital Waiver (0139.R04.00)**

Provides case management/coordination, habilitation, home respite, waiver personal care services, community transition, continuous nursing and supportive services, environmental accessibility adaptations, facility respite, family/caregiver training, medical equipment operating expense, PERS-installation and testing, PERS, private duty nursing including home health and shared services, and transitional case management for **medically fragile and technology dependent individuals of all ages.**

3. **CA HIV/AIDS Waiver (0183.R04.00)**

Provides enhanced case management, homemaker, attendant care, home delivered meals/nutritional supplements, Medi-Cal supplement for infants and children in foster care, minor physical adaptations to the home/specialized medical equipment and supplies, non-emergency medical transportation, nutritional

[12] Medicaid.gov, "1915(c) Home & Community-Based Waivers," https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Home-and-Community-Based-1915-c-Waivers.html

counseling, psychotherapy, skilled nursing/licensed vocational nurse, and skilled nursing/licensed registered nurse to **individuals with HIV/AIDS of all ages.**

4. **CA Pediatric Palliative Care (0486.R01.00)**

Provides care coordination, home respite care, personal care, expressive therapies, family counseling, family training, out of home respite care, and pain and symptom management for **medically fragile and technology dependent individuals ages 0-20**

5. **CA Assisted Living (0431.R02.00)**

Provides assisted living service-homemaker/home health aide/personal care, care coordination, residential habilitation, augmented plan of care development and follow-up, and NF transition care coordination for **aged individuals 65 - no max age and physical and other disabilities for individuals ages 21-64.**

6. **CA Multipurpose Senior Services Program (0141.R05.00)**

Provides care management, respite care, supplemental personal care, adult day care, adult day support center, communication, housing assistance, nutritional services, protective services, purchased care management, supplemental chore, supplemental health care, supplemental protective supervision, and transportation for **aged individuals ages 65 and older.**

7. **CA In Home Operations (0457.R01.00)**

Provides case management/coordination, habilitation services, home respite, waiver personal care, community transition, environmental accessibility adaptations, facility respite, family training, medical equipment operating expense, PERS-installation and testing, PERS, private duty nursing-including shared services, and transitional case management for **medically fragile and technology dependent individuals of all ages.**

8. **CA San Francisco Community Living Support Benefit (0855.R00.00)**

Provides care coordination, community living support benefit in licensed settings, behavior assessment and planning, community living support benefit in housing sites, enhanced care coordination, environmental accessibility adaptations, and home delivered meals for **aged individuals 65 and older and for individuals with physical and other disabilities ages 21-64.**

Drug Medi-Cal Waiver/Addiction Continuum of Care

In August 2015, The Department of Health Care Services (DHCS) announced the CMS approval of California's Drug Medi-Cal Organized Delivery System (DMC-ODS) Waiver amendment. DMC-ODS provides a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidence based practices in substance abuse treatment, and coordinates with other systems of care.

This approach provides the beneficiary with access to the care and system interaction needed in order to achieve sustainable recovery. The DMC-ODS will demonstrate how organized substance use disorder care increases the success of DMC beneficiaries while decreasing other system health care costs. The program's emphasis on outpatient care, opioid agonist medication (e.g., methadone), and ambulatory withdrawal management could be a good match for certain kinds of supportive services programs either as part of permanent supportive housing or as part of a street outreach team.

California's Section 1115 Waiver: Medi-Cal 2020[13]

California's 1115 Waiver Renewal, called Medi-Cal 2020, was approved by CMS on Dec. 30, 2015. This extension allows California to extend its safety net care pool for five years, in order to support the state's efforts towards the adoption of robust alternative payment methodologies and support better integration of care.

The new redesigned pool, now called the **Public Hospital Redesign and Incentives in Medi-Cal or PRIME**, will build upon the state's previous Delivery System Reform Incentive Payment (DSRIP) program.

- PRIME offers a series of incentive awards that encourage hospitals to
  - Take on the financial risk of paying for patients who require unexpectedly high levels of care;
  - Adopt evidence-based quality control procedures that will encourage more use of effective treatments and discourage use of ineffective treatments;
  - Integrate behavioral and physical health care services; and
  - Improve "population health management" by tracking health data across entire populations.
- The terms of the Medi-Cal waiver specifically encourage hospitals to fund complex care management for high-risk medical populations and to fund coordinated care for ex-prisoners as they are discharged from the criminal justice system.
- The state has committed that 60% of all Medi-Cal managed care beneficiaries will receive all or a portion of their care through systems paid through alternative payment methodologies by the end of the demonstration period in 2020.
- As of April 2016, Northern California hospitals participating in the PRIME hospital reform program include:
  - **Marin:** Marin General Hospital
  - **Sonoma:** Healdsburg District Hospital, Sonoma Valley Hospital, Sonoma West Medical Center
  - **Contra Costa:** Contra Costa Regional Medical Center

California is also creating and testing a **new global payment approach for the uninsured**, which will assist designated public hospital systems. The new program establishes a pool of funding set aside to pay for primary care and preventative services for uninsured Californians in the hope of preventing unnecessary visits to the ER and hospital.

- Could be used to fund case management, supportive services (especially outpatient mental health visits, mobile clinics, community health workers), and medical respite care for homeless people.
- Program will help to focus on the value, not volume, of care provided to the uninsured, such as providing more primary and preventive care.
- Approximately $2.9 billion in combined federal and state shares of expenditures has been allocated towards this new approach for demonstration year 11, a portion of which is disproportionate share hospital (DSH) funding. Amounts for future years will be determined after completion of the first required uncompensated care report.

To improve the oral health of children in the state, the state will also implement the **Dental Transformation Initiative (DTI),** a dental pilot project for low income children offering financial incentives to dental providers for delivering necessary preventative care and treatment. The financial incentives will fall within three domains: early childhood preventative dental screening, risk assessment and treatment, and continuity of care.

Medi-Cal 2020 also includes the **Whole Person Care (WPC) pilot program**. Information about WPC is presented in a separate handout.

[13] General information about Section 1115 waivers appears in the Appendix.

HEALTH CARE DELIVERY

MANAGED CARE

Managed Care is a health care delivery system organized to manage cost, utilization, and quality. Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care.

Some states are implementing a range of initiatives to coordinate and integrate care beyond traditional managed care. These initiatives are focused on improving care for populations with chronic and complex conditions, aligning payment incentives with performance goals, and building in accountability for high quality care.

Managed Care in California

- Medi-Cal Managed Care contracts for health care services through established networks of organized systems of care, which emphasize primary and preventive care.
- Medi-Cal providers who wish to provide services to managed care enrollees must participate in the managed care plan's provider network.
- Approximately 10.3 million Medi-Cal beneficiaries in all 58 California counties receive their health care through six main models of managed care: Two-Plan, County Organized Health Systems (COHS), Geographic Managed Care (GMC), Regional Model (RM), Imperial, and San Benito.
    - County Organized Health Systems (COHS)
        - Serves about 1.9M beneficiaries through six health plans in 22 counties, including Marin, Napa, Solano, and Sonoma counties.
        - DHCS contracts with a health plan created by the County Board of Supervisors.
        - Local government, health care providers, community groups, and Medi-Cal beneficiaries are able to give input as the plan is created.
        - Health plan is run by the county.
        - In a COHS county, everyone is in the same managed care plan.
        - The managed care plan that serves Marin, Napa, Solano, and Sonoma counties is **Partnership Health Plan of California**
    - Two-Plan
        - Serves about 5.7M beneficiaries in 14 counties, including Contra Costa County.
        - In each county, there is a Local Initiative (county organized) and a Commercial Plan. DHCS contracts with both plans.
        - The following managed care plans serve Contra Costa County:
            - Commercial Plan: Anthem Blue Cross Partnership Plan
            - Local Initiative: Contra Costa Health Plan
            - Specialty Health Plan: Center for Elders Independence (PACE)
    - Geographic Managed Care (GMC)
        - Serves about 920,000 beneficiaries in Sacramento and San Diego Counties.
        - DHCS contracts with several commercial plans
    - Regional

        - Serves about 230,000 beneficiaries in 18 counties.
        - Two Commercial Plans contract with DHCS.
    - Imperial
        - Serves about 60,000 beneficiaries in Imperial County.
        - Two Commercial Plans contract with DHCS.
    - San Benito
        - Serves about 7,000 beneficiaries in San Benito County.
        - One Commercial Plan contracts with DHCS.
        - Beneficiaries can choose the managed care plan or regular (Fee-for-Service) Medi-Cal.

PATIENT-CENTERED MEDICAL HOMES

A patient-centered medical home (PCMH) is a coordinated care model focused on acute care for all populations. They are typically defined as physician-led primary care practices, which bring together a team of medical professionals (including nurses, nurse care managers, medical assistants, office support staff, and often pharmacists and social workers) to coordinate and personalize medical care.

California Statewide Patient-Centered Medical Homes

California's 2010 Bridge to Reform 1115 Waiver resulted in several changes to the healthcare landscape in the state, including expanding Medicaid coverage, reforming safety-net hospitals, and promoting coordinated systems of care for dual eligibles and persons with disabilities. Under the Bridge to Reform, the California Children's Services Program Demonstration included pilot programs to improve coordination of care through medical homes, improve satisfaction with care, and develop family-centered care. In 2012, a waiver amendment provided for the California Duals Demonstration program - Cal MediConnect - that was implemented in eight California counties in 2014. The program aims to improve care coordination for dual eligible beneficiaries and drive high quality care through medical homes. Cal MediConnect is not currently operating in any Northern California communities.

California encourages issuers selling Qualified Health Plans (QHPs) in the Marketplace, Covered California, to assist enrollees in selecting a primary care provider, Federally Qualified Health Center (FQHC) or a patient-centered medical home (PCMH) within 60 days of enrollment.

Northern California PCMHs

There are a number of health systems operating patient-centered medical homes in Northern California:

- In March 2002, the California HealthCare Foundation awarded grants to local, community-based coalitions in seven communities that are working to: (1) increase the number of medical homes available to children with special health care needs and their families; and (2) increase the number of these children who are connected to such medical homes. The following Northern California communities received grants:
    - **Contra Costa Health Services** (Contra Costa County)
    - **Partnership HealthPlan of California** (Solano, Napa and Yolo Counties)
- In June 2015, the National Committee for Quality Assurance (NCQA) recognized **all Kaiser Permanente's Northern California locations** providing adult and pediatric primary care services with its highest-level accreditation. Fifty-four medical centers where Kaiser Permanente primary care physicians practice were recognized by NCQA as Patient-Centered Medical Homes receiving Level 3 status, the highest level possible.
- The Contra Costa Times reported in 2012 that **John Muir Health**, a health system in Concord, attributes dramatic clinical results to its pilot PCMH. Their data shows a reduction in emergency room visits by 14 percent and reduced overall hospitalizations by 43 percent.

- In December 2014, **Marin Community Clinics** received NCQA PCMH recognition for using evidence-based, patient-centered processes that focus on coordinated care and long-term, patient-provider relationships.
- **Lifelong Medical Care**, which serves both Contra Costa and Marin counties, received recognition as a Level Three PCMH from the NCQA in January 2014.
- In June 2015, **OLE Health** received Level-3 NCQA PCMH recognition. OLE Health is one of only two medical practices (or health care systems) in the Napa Valley Region to receive this recognition, in addition to Kaiser Permanente Northern California.
- **La Clinica De La Raza**, serving Contra Costa and Solano counties, has received NCQA PCMH recognition.

Sonoma County Indian Health Project has received AAAHC accreditation with Patient Centered Medical Home (PCMH) certification. **Santa Rosa Community Health Center** has received TJC ambulatory care accreditation with PCMH certification and **Petaluma Health Center** has attained Level 3 NCQA PCMH recognition.

HEALTH HOMES

A health home offers coordinated care to individuals with multiple chronic health conditions, including mental health and substance use disorders. The health home is a team-based clinical approach that includes the consumer, his or her providers, and family members, when appropriate. The health home builds linkages to community supports and resources as well as enhances coordination and integration of primary and behavioral health care to better meet the needs of people with multiple chronic illnesses.

The Medicaid Health Home State Plan Option, authorized under the Affordable Care Act, allows states to create Medicaid health homes to provide supplemental services that coordinate the full range of physical health, behavioral health, and community-based long term services and supports needed by beneficiaries with chronic conditions.

California Health Homes

- **Background:**
  - AB 361 authorized implementation of the ACA section, creating Health Homes in California
    - Required inclusion of a specific target population of frequent utilizers and people experiencing homelessness
    - Required the health home program include providers with experience serving frequent hospital/ED users and homeless members
  - One of the four initiatives under California's State Health Innovation Plan
- **Covered Population:** Patients with multiple, complex needs who may benefit from enhanced care coordination, with a focus on frequent utilizers of health services, people with severe mental illness and substance abuse disorders or people who are homeless.
  - Opt-out approach
  - Eligible individuals in the Medicaid expansion are included
- **Services Provided:** Enhanced care coordination, team-based care, palliative care, and other services. In addition to medical coordination, other potential focus areas are:
- Mental health and substance use disorder services
  - Services for homeless members, including linkages to supportive housing
  - Coordination and referral for palliative care services
- **Participants/Payers:** DHCS, CalPERS, Covered California (only DHCS will offer a health home payment)
- Involves multiple providers, including community health workers. Providers will receive technical assistance supported by the State Innovation Model grant, including webinars, learning collaborative, and individual practice coaching.
- **Policy Goals:**

    - Preventing and managing chronic disease
    - Improving care experience
        - Improve care coordination - DHCS is assessing care coordination MCOs currently provide to determine what would have to be added to complete the health homes benefit. There should be no duplication of care coordination services.
        - Integrate palliative care into primary care delivery
        - Strengthen community linkages within health homes
        - Strengthen team-based care, including use of community health workers/promoters/other frontline workers
        - Improving population health – improve health outcomes of people with multiple chronic diseases
        - Lowering costs – achieving net cost savings within 18 months
- **Geographic phasing**
    - State intended to start with the Coordinated Care Initiative (CCI) counties as readiness allows beginning in January 2016: Alameda, San Mateo, Santa Clara, Los Angeles, Orange, San Diego, Riverside, San Bernardino.
        - Dually eligible beneficiaries are already in managed care
        - Providers more likely to have experience with enhanced coordination requirements
    - Remaining California counties as readiness allows starting in July 2016
- **Payment methodology**
    - Per member per month, carved into the managed care plan capitation payment
    - Tiering based on patient acuity
    - Payments flow through lead entities to qualified care management entities via contract.
- **California Health Home Network**
    - Lead Entity: Qualifying Medi-Cal Managed Care Plans
        - Maintains overall responsibility for the health home network, including administration, network management, health information technology and exchange (HIT/HIE)
        - Receives health home payment from the state and flows to partners
        - Must partner with one or more community-based care management entities
    - Community-Based Care Management Entities (e.g. FQHCs, hospitals, clinics, IPAs, behavioral health providers)
        - Responsible for providing the core health home services:
            - Comprehensive care management
            - Care coordination (physical health, behavioral health, community-based LTSS) and health promotion
            - Comprehensive transitional care
            - Individual and family support
            - Referral to community and social support services
            - Use of HIT/HIE to link services
        - Dedicated care manager is located within this entity
        - Entity receives payment for health home services via a contract with the plan
        - Makes referrals to community partners for non-Medicaid funded services
    - Community and Social Support Services (e.g. supportive housing providers, food banks, employment assistance, social services)
        - Provides services that meet the enrollees' broader needs (e.g. supportive housing services, social services and supports)
        - May not necessarily receive health home funding

PARTNERSHIP OPPORTUNITIES

MANAGED CARE ORGANIZATIONS

Managed care organizations (MCOs) may pay for services on a fee-for-service basis. However, in recent years, states have moved away from just using a straight fee-for-service payment for many of the health care services covered by Medicaid, relying instead on Medicaid managed care approaches to organizing payment and delivery of medical and/or behavioral health services for growing numbers of Medicaid beneficiaries. Many MCO members, especially in the case of Medicaid MCOs – are people experiencing homelessness. Particularly because those members may be hard to serve and/or user higher cost services, MCOs have an incentive to think strategically about how to effectively serve their homeless members. Some strategies to do so create opportunities for partnerships, including:

1. Targeting resources to those with greatest needs. Develop methods for identifying the highest need/highest cost beneficiaries, which will typically include people who are chronically homeless or have ongoing housing stability problems. Target intensive care management and housing stabilization services for this population.
2. Developing innovative funding strategies for funding the care management and housing stabilization services needed by people who are chronically homeless or at-risk. This includes using funds included in their capitated payment to fund specialized care management or coordination and essential services that are difficult to fund under a fee-for-service system. (This may require State and CMS approvals.)
3. Reinvesting a portion of profits on an annual basis (cost-savings after covering risk and contingency) into housing and other services needed to stabilize the population, and hopefully, allow more cost-savings to be incurred. This is particularly important as a strategy to fund additional PSH, respite housing, and other housing needed by the target population.
4. Working with a range of agencies serving the target population in order to coordinate (not duplicate) resources and support robust and effective interventions that effectively stabilize individuals served. This includes homeless housing and service providers who have expertise with the population.

ACCOUNTABLE CARE ORGANIZATIONS (ACOS)

Accountable Care Organizations (ACOs) are provider-run organizations that consist of a network of health care providers and organizations like hospitals, managed health care plans, and doctors, which come together voluntarily to give coordinated care to their patients. ACOs represent a relatively new payment model for delivering health care that coordinates all the different health care services a patient receives, breaking down traditional health care silos. The focus is on containing the overall cost of care. ACOs typically include 3 key elements:

(1) Provider-run organization at base
(2) Accountability for shared outcomes
(3) Potential for shared savings

Participating providers are collectively responsible for the care of an enrolled population and may share in any savings associated with improvements in the quality and efficiency of the care they provide. Provides direct patient-centered care management and coordination:

- Targeted and intensive complex care management, tailored to high-need/high-cost patients with cross-functional care teams
- Data infrastructure and analytics
- Motivated and mission-driven leadership and providers empowered to transform care delivery, build cross-functional teams/structure for meaningful patient and community partnerships

- Capacity to address social needs

Medicaid ACOs must also meet quality of care standards, and receive a share of any savings achieved when they deliver health care at lower costs than budgeted for per-member payments. These payments create a strong incentive for ACOs to invest in preventative care for their patients.

Because ACOs have incentives to reduce costs, housing providers would make excellent members of care teams and can partner with ACO provider groups. If affordable housing providers can demonstrate ability to support the health of patients, ACOs may provide funding to housing providers to deliver non-medical services such as health education and hospital discharge planning. Housing providers can also help ACOs conduct outreach to inform low-income households about their eligibility to enroll in ACOs, since outreach to Medicaid enrollees is often a major challenge for ACOs.

However, ACOs come with the following challenges:

- Require substantial initial investments in capacity-building and infrastructure development.
- States or purchasers/providers must negotiate payment models aligning financial incentives to serve patients with greatest needs and risks.
- Existing risk-adjustment methodologies do not capture factors associated with social determinants of health.

PUBLIC HOSPITALS AND HEALTH SYSTEMS

Under the ACA, nonprofit hospitals are now required to complete a community health needs assessment (CHNA) every three years. The objective of the CHNA is to assess the most prevalent health needs and barriers to accessing health care and maintaining good health in the community. These needs assessments can demonstrate to hospitals the health benefits of stable housing and encourage financial investments aimed at increasing housing stability.

Case Study: St. Joseph Health System[14]

In Orange County CA, the **St. Joseph Hospital System has been investing in the construction of affordable housing based on its CHNAs, which revealed the major impact that lack of affordable housing has had on the health of its community**. There are currently 82 low-income housing units for seniors slated for development in Anaheim and there are plans to build a development for large families in the near future. Funding for the senior housing was secured from the City of Anaheim and loan funding for the land from SJHS.

St. Joseph is also a founding member of the Kennedy Commission, an organization devoted to advocating for affordable housing in Orange County, lending an important voice to efforts to expand affordable housing in the community. The chair of the County Board of Supervisors recently informed the partnership that its support resulted in the allocation of $35 million from the county's general fund to support low-income housing over the next five years.

[14] Kevin Barnett, DrPH, MCP, "Best Practices for Community Health Needs Assessment and Implementation Strategy Development: A Review of Scientific Methods, Current Practices, and Future Potential," Public forum convened by the Centers for Disease Control and Prevention, Atlanta, Georgia, July 11-13, 2011: 2. http://www.phi.org/uploads/application/files/dz9vh55o3bb2x56lcrzyel83fwfu3mvu24oqqvn5z6qaeiw2u4.pdf.

Case Study: Florida Hospital[15]

In November, 2014, the **Florida Hospital in Orlando, FL announced a $6 million pledge to address homelessness in Central Florida, with the goal of housing 300 of Orlando's chronically homeless individuals in three years.** $4 million will be earmarked to support PSH units using a Housing First model. The Florida Hospital's contribution will serve as the kick-off investment in the Central Florida Foundation's new "Impact Homeless Fund," a collaborative, public and private investment-solutions vehicle to help those facing homelessness in Orange, Osceola, and Seminole Counties.

COUNTY HEALTH DEPARTMENTS

Case Study: Los Angeles Housing for Health Program[16]

Background: The Housing for Health (HFH) Program is an ambitious program by the Los Angeles County Department of Health Services (DHS) to link housing, health, and behavioral health services for the same population through linkages with housing providers and DHS's own network of County hospitals, clinics, and contracted service providers that are part of its health services safety net.

- HFH's primary target population is people experiencing homelessness who are extremely vulnerable because of their health conditions or who are frequent users of County hospital emergency rooms or inpatient care.
- HFH draws from a variety of housing options, including PSH units, licensed residential care and recuperative care facilities, temporary housing for people experiencing short-term crises, and interim housing where people can stay while completing the application process for permanent housing.

PSH Funding:

- HFH leverages the services funding it receives from DHS to secure housing opportunities and additional funding resources.
    - Initially, the County did not pay for the cost of housing itself, securing HFH's housing inventory by funding the associated property management and supportive services instead.
    - For example, HFH's first PSH units were created by attaching DHS-funded service teams to tenant-based Housing Choice Vouchers provided by City and County public housing authorities. DHS also partnered with the City Housing Department to acquire and renovate houses and apartment buildings that were in foreclosure.
- In response to the 2013 federal sequestration, which froze the issuance of new housing vouchers, the County began funding housing directly. In addition, DHS worked with the County Board of Supervisors and the Conrad N. Hilton Foundation to launch an $18 million Flexible Housing Subsidy Pool (FHSP) to provide housing subsidies lined with wraparound intensive case management services for at least 2,400 persons.
    - DHS contracted with Brilliant Corners (BC), a nonprofit organization, to administer the FHSP. BC has been able to maximize the impact of the FHSP dollars by searching for available rental units all over the County, assisting project participants in being matched to the right unit, contracting directly with landlords for units in scattered-site or project-based buildings, and offering special 2-month leases to landlords to take units off the market and hold them for future referrals.
- DHS has managed to finance HFH's property management and supportive services from its existing budget
    - Most of DHS's contributions to HFH were already in its departmental budget, where they were

[15] Corporation for Supportive Housing, "Florida Hospital Pledges Millions to End Homelessness," November 12, 2014, http://www.csh.org/2014/11/florida-hospital-pledges-millions-to-end-homelessness/.
[16] ASPE, "Medicaid and Permanent Supportive Housing for Chronically Homeless Individuals: Emerging Practices from the Field, "August 2014, available at: http://aspe.hhs.gov/daltcp/reports/2014/EmergPrac.pdf.

covering the costs of care delivered in DHS's health service facilities that were not reimbursed through insurance.
    - In addition, the advent of Healthy Way LA, the County's Low Income Health Program, and its federal Medicaid match for the costs of care, freed up those local resources, making them available for DHS to cover the cost of supportive services.
    - DHS has also determined that its contributions to HFH are offset by major reductions in spending for emergency department use, hospitalizations, and re-hospitalizations by the target population, as well as stays in other high-cost settings such as jails and nursing homes.
- DHS uses a Request for Qualifications process for its property management and supportive services contracts, which has contributed to HFH's ability to take advantage of housing opportunities in a timely manner.
    - DHS established master contracts with 8 property management companies and about 20 supportive service providers. Once housing becomes available and HFH places its priority people into it, DHS adds specifics to those master contracts, entering into agreements for the number of people to receive supportive services or the number of units to receive property management services.

APPENDIX: MEDICAID OPPORTUNITIES UNDER THE AFFORDABLE CARE ACT (ACA)

The information in this Appendix is provided as background to better understand Medicaid opportunities available to integrate and fund housing and health care resources for people experiencing homelessness and low-income people living with HIV/AIDS. Some California-specific information is presented earlier in this handout.

To expand services covered through Medicaid, a state can adopt waivers or propose state plan amendments (SPAs) to the Centers for Medicare and Medicaid Services (CMS).

- A **waiver** is an exception to restrictions on what services can be reimbursed through Medicaid.
- A **SPA** is a proposed set of changes that when accepted become part of the amended state plan.

MEDICAID WAIVERS, AMENDMENTS, AND FUNDING OPPORTUNITIES

Option	Did it exist pre-ACA?	Who qualifies?	What services are covered?
(1) HCBS- 1915(i) SPA	Yes	Individuals who can live in the community but need a range of services to do so.	Case management, personal care, adult day health, home health aide, and psychosocial rehabilitation.
(2) HCBS-1915(c) Waiver	Yes	Individuals whose disability level meets eligibility for institutional care.	Case management, home health aide, personal care, adult day health, and respite care.
(3) 1915(k) Waiver - Community 1st Choice	No	Individuals who would otherwise need institutional care.	Home attendance assistance with daily living and health related tasks.
(4) 1115 Waiver	Yes	Proposed by State.	Proposed by State.
(5) Health Homes	No	Individuals with chronic health conditions or serious mental illness.	Care management and coordination, transitional and follow-up care, referrals.
(6) Center for Innovation Demonstration Project	No	Proposed by State.	Proposed by State.
(7) Rehabilitation Option	Yes	Individuals who need to attain/retain independence or self-care abilities.	Medical and remedial rehabilitation services, including diagnosis and screening.

(1) Home and Community-Based Services (HCBS)-1915(i) State Plan Amendment

- Allows Medicaid beneficiaries with disabilities to receive services in their home or community as an alternative to institutional care such as nursing homes.
- CMS will allow states to provide HCBS benefits for specific populations through a state plan amendment, provided the state can meet all federal requirements:
    - Beneficiaries must be elderly or people with disabilities.
    - Beneficiaries must have incomes not more than 150% of FPL or up to 300% of SSI.
    - Beneficiaries must meet access to care criteria (less than that of institutional care).
    - Beneficiaries must have a choice in providers.

    - The benefit must be implemented state-wide.
    - The state must serve all beneficiaries who meet the benefit's eligibility criteria. It cannot limit the number of people who will be served, nor limit based on diagnosis, type of illness, or condition.
    - The state must demonstrate it can provide its share of the cost of the program.
- Provides a 50/50 federal-state reimbursement rate (or higher, depending on the state) to fund case management, personal care, adult day health, and home health aide services.
- For individuals with mental illness, it also covers psychosocial rehabilitation services.
- Existed before the ACA, but the ACA expanded its scope by:
    - Making individuals earning up to 150% of the Federal Poverty Line eligible under it
    - Giving states additional flexibility in the range of covered services proposed
    - Giving states flexibility in defining the targeted population group
    - Eliminating eligibility wait lists by removing the cap on the number of enrollees

Relevance: This amendment could be used to provide care to some of the most vulnerable tenants in supportive housing.

- Significant overlap between chronically homeless people and those who would qualify for services under this SPA.
- Many services covered under 1915(i) overlap with those commonly provided by supportive housing programs (e.g. case management, treatment planning, counseling, transportation, and life skill development).

(2) HCBS-1915(c) Waiver

- Similar to the 1915(i) amendment: provides case management, psychosocial rehabilitation, and other services for individuals with serious mental illness or other disabling conditions.
- Applies exclusively to individuals who meet a state's eligibility requirements for institutional care (due to mental disabilities, physical disabilities, developmental disabilities, old age, etc.).

Relevance: Same as 1915(i) SPA, but would apply to narrower group.

(3) HCBS-1915(k) Waiver – Community First Choice Option

- Provides for daily living assistance services to persons who would otherwise need to be housed in a skilled nursing facility.
- Under this waiver, when an individual is moved from an institution into a community, states may contribute to such expenses as security and utility deposits, first month's rent, and basic household supplies.

Relevance: Could apply to supportive housing residents with severe mental illness and substance abuse issues or other severely disabling conditions.

(4) 1115 Waiver

Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects that promote the objectives of the Medicaid and CHIP programs. The purpose of these demonstrations, which give states additional flexibility to design and improve their programs, is to demonstrate and evaluate policy approaches such as:

- Expanding eligibility to individuals who are not otherwise Medicaid or CHIP eligible;
- Providing services not typically covered by Medicaid; or
- Using innovative service delivery systems that improve care, increase efficiency, and reduce costs.

The 1115 Waiver mechanism allows a state to apply to expand eligibility, restructure funding or payment processes, or use Medicaid to fund nearly any type of conceivable service if the state can illustrate a medical necessity and demonstrate that the proposed changes will have a budget-neutral effect (i.e., over a five-year period, the demonstration project must result in no additional federal spending than if the program did not exist).

- May target specific populations for receipt of 1115 Waiver services.
- Once approved, 1115 demonstration projects remain in effect for five years, with the possibility of renewal.

Relevance: Post-ACA, states are beginning to make the case to CMS that providing funding for housing assistance, for example, can reduce expenditures in other areas, such as ER usage.

(5) Health Homes

- Established by the ACA.
- A coordinated team of health care providers or agencies that provides a comprehensive system of care coordination for individuals with chronic health conditions
- States have a lot of flexibility in how they set up their health homes: a state Medicaid plan may contain multiple health home provisions that target different populations.
- To create a health home, a state applies to CMS for permission to include in its Medicaid plan.
    - The state defines the desired target population, what services the health home will provide, and how it will operate.
    - Once approved, for the first two years of a health home's existence, the federal Medicaid match rate for services provided by the health home is 90 percent, after which the rate equals that for standard Medicaid services in that state.

(6) Center for Innovation Demonstration Projects

- ACA established the Center for Medicare and Medicaid Innovation (CMMI), which periodically issues RFPs for demonstration projects: innovative health care delivery approaches that may achieve better health outcomes and cost efficiencies.
- **Health Care Innovation Awards:** to organizations implementing the most compelling new ideas to deliver better health, improved care and lower costs to people enrolled in Medicare, Medicaid and Children's Health Insurance Program (CHIP), particularly those with the highest health care needs.
- **Health Care Innovation Awards Round Two:** to applicants testing new payment and service delivery models that will deliver better care and lower costs for Medicare, Medicaid, and/or CHIP enrollees.

(7) Rehabilitation Option

- Covers services that are specifically rehabilitative: they must help a person to regain functions that have been lost in some way.
- In some states, therapy, counseling, and other mental health services may be reimbursable under this authority.

HOUSING & HEALTH CARE: CROSS-SYSTEM COORDINATION

THE CONNECTION BETWEEN HOUSING AND HEALTH CARE NEEDS

- **Housing is a Key Determinant of Health.** Poor living conditions, caused by poverty and homelessness, affect people's vulnerability to illness and disease, and their abilities to benefit from treatment and manage their conditions. People who are homeless contend with contact with communicable diseases and infections, exposure to extreme weather, malnutrition, stress, lack of running water to maintain cleanliness, and lack of refrigeration for medication.[1]
- **People who are Homeless are at Greater Risk for Poor Health.** They have high rates of infectious and acute illnesses (skin diseases, TB, pneumonia, asthma); chronic diseases (diabetes, hypertension, HIV/AIDS, cardiovascular disease); poor mental health, substance abuse, or both; and being victims of violence. Their mortality rate is 3-4 times higher than for the general population.[2]
- **Health Issues Are Likely to Increase as the Homeless Population Ages.** The number of homeless people in the U.S. between the ages of 51-61 increased 32% from 2007 to 2013.[3] Rates of chronic health conditions and potential for extended stays in nursing homes increase with age.
- **HIV/AIDS is Correlated with Homelessness.** Many domiciled individuals face the threat of homelessness once they or someone in their family becomes infected with HIV/AIDS. Additionally, people experiencing homelessness are at risk of contracting HIV due to the prevalence of high-risk behaviors like injection drug use, unsafe sex, and "survival sex" (i.e., exchanging sex for food, shelter, or money).[4] Studies indicate the prevalence of HIV among homeless people can be as high as 20%.[5]
  - → Lack of housing has been identified as one of the top 5 barriers for HIV+ persons accessing medical care.
  - → The National Alliance to End Homelessness estimates that 3.4% of homeless people are HIV-positive, compared to 0.4% of adults and adolescents in the general population.[6]
  - → 21.7% of HIV+ respondents to a services needs survey indicated they were homeless at some point in the last year. [7]
- **Homelessness Is Correlated with High Health Care Costs.** The high proportion of complex health needs and co-occurring health and behavioral health disorders increases the number, intensity, and

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[1] *Social Determinants of Health,* Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services, retrieved March 30, 2015, http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health.
[2] http://www.cdc.gov/features/homelessness/ and Kaiser Commission on Medicaid and the Uninsured, "Medicaid Coverage and Care for the Homeless Population: Key Lessons to Consider for the 2014 Medicaid Expansion", September 2012, available at: http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8355.pdf
[3] End Chronic Homelessness Policy Academy Team presentation delivered at Washington Legislature Adult Behavioral Health System Task Force Meeting on September 19,2014. For more information, please contact Gillian Morshedi (gillian@homebaseccc.org) at HomeBase.
[4] St. Lawrence, J., Brasfield, T.L. (1995). HIV risk behavior among homeless adults. AIDS Education and Prevention, V. 7, 22-31. Guildford Press: New York.
[5] National Coalition for the Homeless, (2007). HIV/AIDS and homelessness [Online], www.nationalhomeless.org/publications/facts/HIV.pdf
[6] National Coalition for the Homeless, (2007). HIV/AIDS and homelessness [Online], www.nationalhomeless.org/publications/facts/HIV.pdf
[7] Rickles, M. Ryan White Part A Nashville Transitional Grant Area 2015 Needs Assessment. Nashville Regional HIV Planning Council. 2015. nashrpc.com/data

scope of the services needed. Homelessness inhibits the long-term, consistent care needed for many of these conditions, aggravating the problems and making them more dangerous and costly. Homelessness increases the likelihood of excessive use of the emergency room, inpatient treatment, and crisis services.

→ Of 6,601 unique individuals identified as homeless in Contra Costa County, 3,170 also utilized mental health, primary health, or alcohol and drug treatment offered through the Contra Costa Health Services Department for a total of **$45,412,145 in public health costs.**[8]
→ A 2015 study, "Home Not Found: The Cost of Homelessness in Silicon Valley," found that more than **$3 billion** in services went to homeless residents of Santa Clara County over six years, including $**1.9 billion for medical diagnoses and the associated health care services.**[9]
→ In California, the Frequent Users of Health Services Initiative found that approximately **45 percent of individuals who were high utilizers of emergency departments were homeless**.[10]

FOCUS ON "MAINSTREAMING" AT THE FEDERAL LEVEL

The U.S. Department of Housing and Urban Development ("HUD") strongly encourages and incentivizes communities to apply the resources of a broad spectrum of health, education, human, and social services programs to the response to homelessness. This "mainstreaming" approach is also found in the Homeless Emergency and Rapid Transition to Housing (HEARTH) Act of 2009. HUD's study, "Strategies for Improving Homeless People's Access to Mainstream Benefits and Services," found that communities intent on improving access to mainstream services had success reducing structural barriers.[11]

The U.S. Interagency Council on Homelessness (USICH)'s "Opening Doors: Federal Strategic Plan to Prevent and End Homelessness," as amended in 2015, outlines an interagency collaboration that aligns mainstream housing, health, education, and human services to prevent Americans from experiencing homelessness.[12] The Plan emphasizes the full integration of targeted programs with mainstream programs, and calls on all relevant mainstream programs to prioritize housing stability for people experiencing or at risk of homelessness.

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8 Contra Costa Behavioral Health, "Cost of Homelessness: A Snapshot of Healthcare Cost to Homeless Consumers in Contra Costa County," Presented to the Council on Homelessness General Membership Meeting, July 24, 2015.
9 Economic Roundtable, "Home Not Found: The Cost of Homelessness in Silicon Valley," 2015: 18. http://destinationhomescc.org/wp-content/uploads/2015/05/er_homenotfound_report_6.pdf
10 Linkins, Brya, & Chandler, 2008, available at: http://www.aidschicago.org/pdf/2009/hhrpn/FUHCS/1-FrequentUsersofHealthServicesInitiative-FinalEvaluation.pdf
11 Martha Burt, et al, "Strategies for Improving Homeless People's Access to Mainstream Benefits and Services," March 2010, http://www.huduser.org/portal/publications/povsoc/homeless_access.html
12 U.S. Interagency Council on Homelessness, "Opening Doors: Federal Strategic Plan to End Homelessness," Amended 2015: 29,42. http://usich.gov/resources/uploads/asset_library/USICH_OpeningDoors_Amendment2015_FINAL.pdf.

MODEL STRATEGIES AND CROSS-CUTTING ISSUES

The following are five model strategies to consider in developing a housing-healthcare integration action plan:

1. **Enrollment:** Facilitate Enrollment of People Who Are Homeless and At-Risk in Medicaid and Other Benefit Programs
2. **Access:** Facilitate Access to Care, Engagement with Providers, and Appropriate Use of Health Services
3. **Integration:** Integrate Housing, Health, and Other Services to Facilitate Housing Retention and Ongoing Wellness
4. **Data:** Develop Data-Driven Service Interventions Targeted to Priority Sub-Populations
5. **Medicaid:** Maximize Use of Medicaid to Finance Services that Support Housing Stability, including Permanent Supportive Housing services and Recuperative / Transition Care

Additionally, the following **cross-cutting issues** should be considered as part of implementation planning:

- **Training:** What training will be needed for staff?
- **Partnerships:** What partnerships are needed and how can they be forged?
- **Targeting:** Should particular sub-populations be targeted? If so, how should they be identified?
- **Scale:** What will be needed to bring the strategy to a scale appropriate to meet the need?
- **Systems:** How can individual programmatic efforts be aligned into a unified system working toward shared outcomes?

A detailed framework of model strategies and supporting action steps is available at homebaseccc.org under the Resources tab.

IDEAS COMMUNITIES ARE CURRENTLY EXPLORING NATIONWIDE

Key ideas that have emerged regarding ways to facilitate coordination between housing and health care providers to improve access to health care and other supportive services include:

- Hold regular meetings with housing and health care (and other supportive services) providers, preferably building upon existing forums or coalition meetings. Consider devoting a portion of each meeting to an in-depth conversation about a specific topic (e.g., Coordinated Entry; obligations of Managed Care organizations to serve members) and strategically inviting stakeholders based on the topic. The purpose is to engage in cross-system education, about how systems operate and the needs and incentives of various providers.
- Institute case conferencing for highly vulnerable and/or higher cost clients that have housing, health, and other needs. Case conferences should include representatives from the CoC/housing system as well as health care stakeholders.
- Pilot "Frequent user" programs to identify and target resources to people with housing needs that also have health care (primary and/or behavioral) and other supportive service needs.
- Improve discharge planning protocols at hospitals, jails/prisons, psychiatric institutions. Discharge planning process should begin at point of admission and include a housing aspect/connection to the CoC.
- Develop partnerships between CoC and Federally Qualified Health Centers (FQHCs), including locating FQHC clinics on-site at shelters and/or permanent housing buildings, or having mobile vans visit shelters and outreach to unsheltered people.

- Build relationships between CoCs and managed care organizations, especially Medicaid managed care organizations.
    - CoC agencies can provide assistance with identifying, locating, and connecting "missing" members with MCOs. Possibility of MCO providing "finders" fee to CoC for this assistance.
    - Managed care organizations (or hospitals) may also be willing to fund recuperative care beds to save costs associated with patients staying in inpatient care longer than medically necessary as a result of not having an adequate place to live while finishing treatment.
- Connect health care and supportive service providers that are not part of a HUD-funded CoC system to the appropriate Coordinated Entry System.
    - Formally: e.g., non-CoC providers entering some data into HMIS; CoC agency staff located on-site at hospitals, especially emergency departments
    - Informally: non-CoC providers simply being aware of entry points into Coordinated Entry System and how to connect patients that need housing assistance to those points
- Educate housing/homeless assistance providers about how Medicaid can fund supportive services:
    - What supportive services are covered by California's Medicaid plan?
    - What existing Medicaid providers in the area provide or could provide those services, or would be willing to contract with non-Medicaid providers - such as CoC agencies - to provide those services to Medicaid enrollees?

ADDITIONAL RESOURCES

- Healthcare and Housing Systems Integration Working Tools: available for beta testing and feedback at www.homebaseccc.org under the Resources tab. This suite of resources includes a more detailed version of the Model Strategies and Framework excerpted above.
- HUD's Housing-Healthcare Integration (H^2) website: information about 20 action planning sessions conducted around the United States between December 2014 and May 2016, including emerging action plans, community-specific resource guides, and contact information for those leading the implementation efforts. www.hudexchange.info/programs/aca/h2/
- HUD's Patient Protection and Affordable Care Act website: information and resources relating to the intersection of housing and health care, including webinars, listserv messages, and a guide to key health resources for grantees and sub-recipients of the CoC, ESG, and HOPWA programs. www.hudexchange.info/programs/aca/h2/

HOUSING-HEALTHCARE SYSTEMS INTEGRATION: STAKEHOLDER CHECKLIST

The following is a list of potential stakeholders to consider engaging to support efforts to coordinate and integrate across service and treatment systems.

Housing
Continuum of Care (CoC) Coordinators
Permanent Supportive Housing Providers
Other Housing Providers (e.g., Rapid Rehousing providers, Emergency Shelters)
Supportive Service Providers
HOPWA Providers
Public Housing Authorities
HMIS administrators
Healthcare
FQHCs (Federally Qualified Health Centers) / Community Health Centers
Healthcare for the Homeless Programs
Hospitals and medical facilities (including VA medical centers)
Mental Health/Behavioral Health agencies
Managed Care Organizations & Behavioral Health Organizations
Ryan White Providers
Primary Care Association
Hospital Association(s)
Free clinics and Indigent Care Clinics
SAMHSA Grantees (including CSAT and CMHS grantees)
Rural Health Clinics/Rural Health Centers
Accountable Care Organizations
Health and Human Services
Department of Health
Indian Health Services/Indian Health Care Providers (including tribal clinics)
Federal Agencies
HUD Field Office and CPD Directors
HRSA and SAMHSA Regional Administrators
Dept. of Justice
Dept. of Labor
USDA (Office of Rural Development)
Centers for Medicare and Medicaid Services (CMS)
Dept. of Veterans Affairs
Dept. of Education
USICH Regional Coordinators
Insurance
State Medicaid Program
County/Local Health Plans (if applicable)
Centers for Consumer Information and Insurance Oversight (CCIIO) Grantees
Criminal Justice
Funding Programs

HOUSING & HEALTH CARE COORDINATION: **WHAT NEXT?**

WHAT AM I GOING TO DO BEFORE THE NEXT RSC MEETING?

Learn more about the connection between housing and health care and what other communities around the state or country are doing in this area

- What specifically do I want to explore further?

    Background information and evidence supported housing as a determinant of health
    Information about specific types of health care stakeholders
    Frequent user studies and/or programs
    Discharge planning
    Involving health care providers in Coordinated Entry
    Medicaid
    Data sharing
    Other: ____
    ____
    ____

- Where will I begin looking? ____

    ____

Share information about the connection between housing and health care

- With whom? ____

    ____

- How? ____

    ____

Make a list of potential health care partners in my community

- Initial ideas: ____

    ____

Reach out to 1 or more potential new health care partners in my community

- Which ones? ____

    ____

Invite at least one health care stakeholder to a housing-centered meeting

- Potential meetings: ____

  ____

  ____

- Potential topics: ____

  ____

  ____

- Potential health care invitees: ____

  ____

  ____

Other: ____

____

____

____

____

WHOLE PERSON CARE PILOTS

SUMMARY

The Whole Person Care (WPC) pilot application evaluation was a competitive process that resulted in the selection of qualified WPC pilots based on the quality and scope of their applications. The Department of Health Care Services (DHCS) conducted the evaluation process in two phases: (1) Quality and Scope of Application and (2) Funding Decision. The following California communities were chosen for this funding stream:

1. Alameda County
2. Contra Costa County
3. Kern County
4. Los Angeles County
5. Monterey County
6. Napa County
7. Orange County
8. Placer County
9. Riverside County
10. San Bernardino County
11. San Diego County
12. San Francisco County
13. San Joaquin County
14. San Mateo County
15. Santa Clara County
16. Shasta County
17. Solano County
18. Ventura County

Through collaborative leadership and coordination among public and private entities, these pilots will:

- Identify common patients who are high users across multiple systems (the target population),
- Share data between systems,
- Coordinate care in real time, and
- Evaluate individual and population progress.

TARGET POPULATION

The target population for these grants are high-risk, high-utilizing Medi-Cal beneficiaries touching multiple systems (e.g. health, behavioral health, etc.). The target population shall be identified through a collaborative data approach to identify common patients who frequently access urgent and emergent services. The target population may include but are not limited to individuals:

- With repeated incidents of avoidable emergency use, hospital admission, or nursing facility placement;
- With two or more chronic conditions;
- With mental health and/or substance use disorders;
- Who are currently experiencing homelessness; and/or
- Individuals who are at risk of homelessness, including individuals who will experience homelessness upon release from institutions (such as hospital, sub-acute care facility, skilled nursing facility, rehabilitation facility, IMD, county jail, state prison or other).